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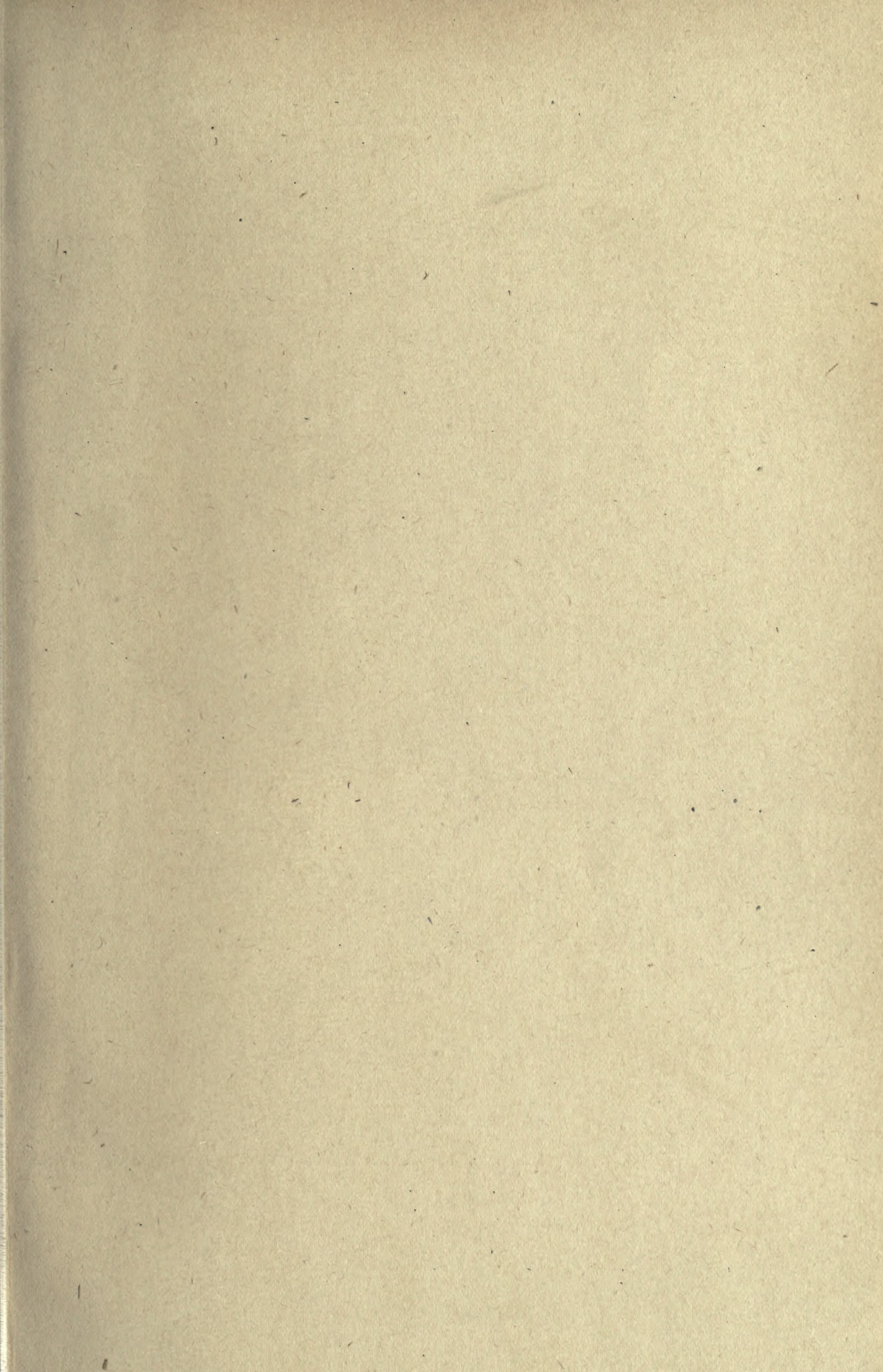
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THE HOSPITAL WORLD

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CONTENTS

EDITORIALS

	Page
Assistance to Hospitals and Sanatoriums.	1
The Gravenhurst Fire.....	4

ORIGINAL CONTRIBUTION

Better Hospitals. By J. N. E. Brown, M.B., Toronto.....	8
---	---

CANADIAN HOSPITALS

	Page
Forty-sixth Annual Meeting of the Toronto Hospital for Incurables	15
Hospital Nurses at Petrolea Graduate.	18
Guelph to Have Insane Asylum....	21
Nursing Mission Holds Thirty-first Annual Meeting	23
The Hospital for Sick Children Training School	25
Fire at Muskoka Free Hospital for Consumptives.	28
Toronto's Hospital Needs	30
Committee Favors a Municipal Hospital.	31

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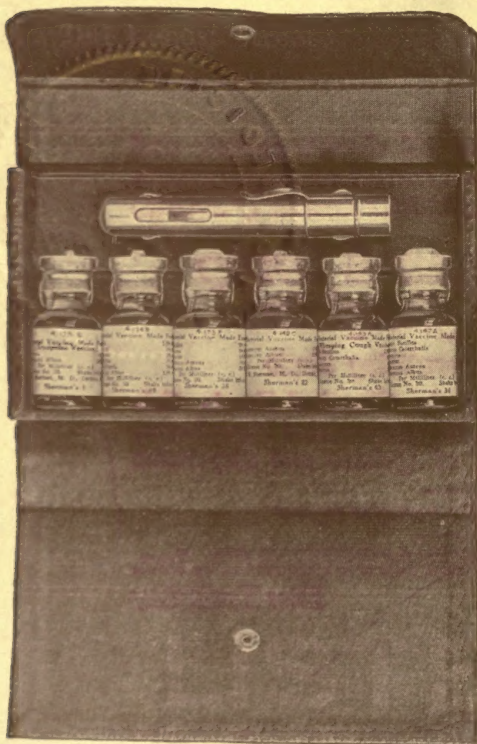
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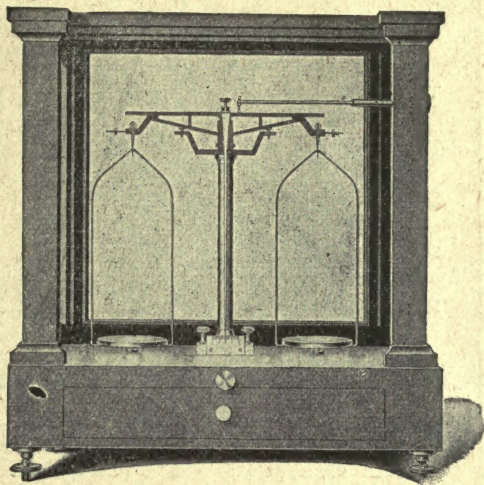
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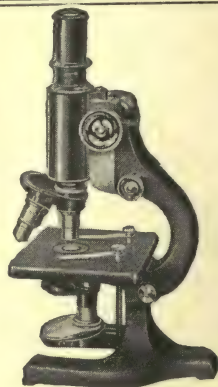
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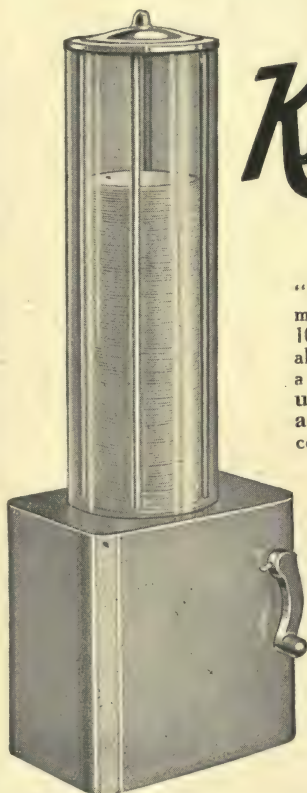
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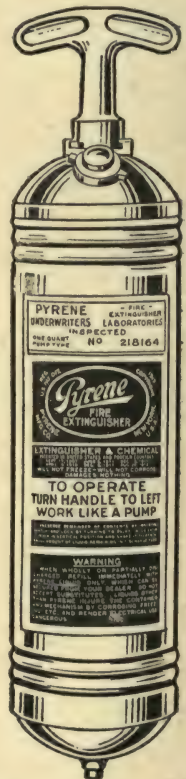
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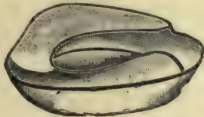
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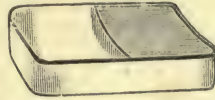
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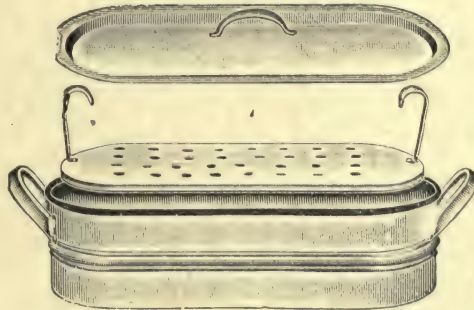
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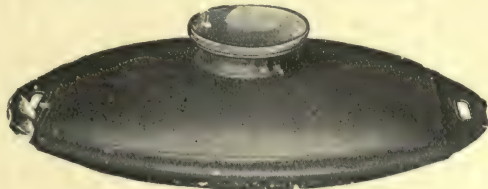
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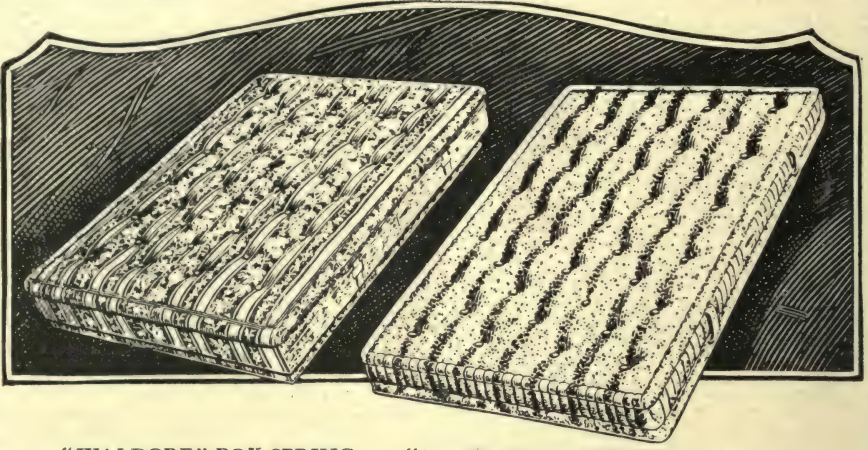
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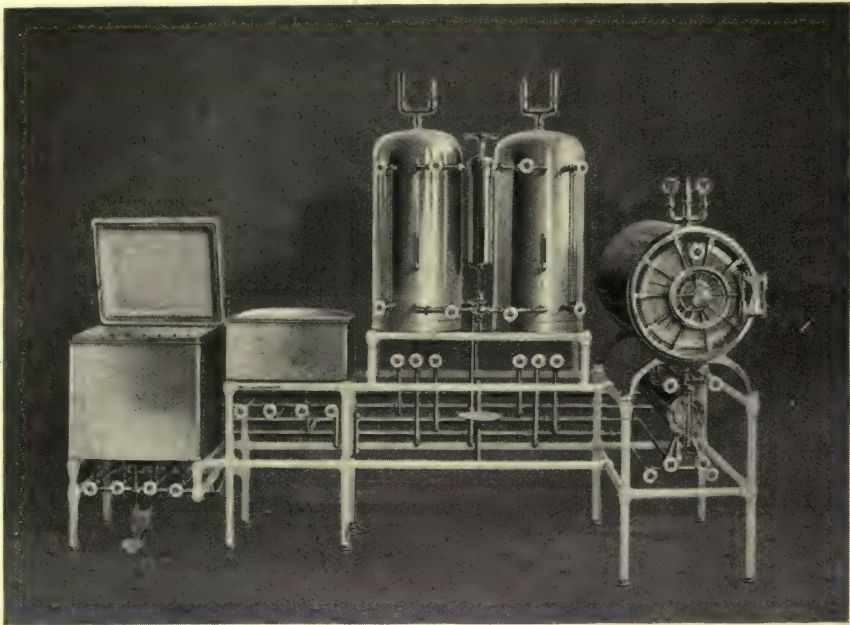
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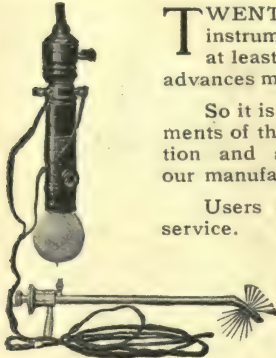
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The Hospital World

TORONTO, CANADA

**A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire**

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No. 1

Editorials

ASSISTANCE TO HOSPITALS AND SANATORIUMS

SIR WILLIAM GAGE and his associates recently appealed to the Provincial Government for a grant of \$75,000, and to the city of Toronto for a similar amount. The Premier pointed out to the delegation that, inasmuch as 63 per cent. of the patients treated by the National Sanatorium Association came from Toronto, the city should pay that percentage of the amount required. The Mayor of Toronto contended that the city was doing its share for the city charitable institutions.

The Sick Children's Hospital is also applying for a grant from Toronto to meet its deficit of \$145,043; the Toronto General Hospital, it is said, will, too, ask for \$150,000. Grace Hospital follows suit with its deficit of \$19,608; and the Western, \$22,510.

The amount to be requisitioned by St. Michael's has not, at this writing, been announced.

The whole question of hospital support is one that will have to be considered soon very seriously, not only by the province, but by the city as well. It has been suggested that a Commission should be appointed which should inquire into the whole situation. It would have plenty to do.

Inquiry might well be made into the question of purchasing of supplies. Economies might be effected by having one purchasing agent or central bureau. Investigation might be made by competent persons as to whether supplies requisitioned for might not be cut down; have they been used too lavishly? Have the sorts which are cheaper and just as effectual been asked for instead of the dearer and more fancy articles? For example, it has been drawn to our notice by a staff member that the dearer and more elegant preparations of silver were being used in a certain o.p.d. when the very much cheaper silver nitrate might have been used. Inquiry might be made as to the use of the very expensive nitrous oxide and oxygen for anaesthesia instead of the much cheaper and safer ether. Selection of instruments and expensive articles of equipment and furniture might well come under supervision. And there are hundreds of items of this sort which might also be considered.

The matter of staff appointments should also be looked into. The formation of close corporations

of men who form cliques for self-aggrandisement does not popularize the hospital in the minds of the outside physicians. Their credentials might well be considered by an impartial commission. Too often appointments are made for other reasons than thorough training and capacity.

The Commission might inquire whether it is right for members of staff to give their services without pay. Members of other professions and trades do not work for hospitals for nothing.

The free treatment of patients might be looked into and the fundamental reason for their poverty and inability to pay might be investigated.

The Commission might spend a few sessions in considering also the question of nursing. In how far are hospitals still exploiting their nurses, or, on the other hand, insisting on pressing in special nurses where staff nurses could do the work.

The payment of hospital employees a decent wage and the subject of pensioning them might be another point to look at.

The establishment of group clinics, such as that at Rochester, where medicine and surgery are so well practised that the institution much more than stands on its own feet, might also be worthy of contemplation. Until conditions become ideal, a leaf might be taken from the hospital book of London and New York. In both these cities there is a Hospital Sunday—one Sunday in each year on which appeals are

made from the pulpits of all the city churches for contributions to hospital support. The amount collected is divided on a *pro rata* basis.

THE GRAVENHURST FIRE

OUR big institutions, in one sense, are one-man affairs. In combating tuberculosis in Ontario the man who has chopped down the trees in this pioneer work is Sir William Gage. Everyone with a heart feels very sorry for the big loss the people of this country have sustained in the disastrous fire at Gravenhurst, described in another column. We must extend our sympathy to Sir William and his associates and express the hope that the work of reconstruction will begin soon, and that the people generally, the City of Toronto and the Provincial Authorities will hold up Sir William's hands.

Owing to extremes of heat and cold in this our rigorous northern clime the problem of fighting the White Plague is beset with peculiar difficulties. As has been pointed out by the popular and energetic secretary of the National Association, Dr. Geo. Porter, tuberculosis as a disease is a medical problem. Its prevention and control is a social one. Our death rate is less than in European countries. Canada is fourth on the list. Unfortunately, our mortality tables are not as complete and as accurate as they should be. There were 9,096 deaths from the disease last year in a population of some eight

million. There were 9,707 in 1901. The decrease in the rate during the two decades has been of over 30 per cent. This has resulted from the establishment of Sanatoriums and Dispensaries throughout the country, the establishment of Clinics and Health centres and Preventoriums in our cities; the inspection of schools, etc. A fine bit of work has been done, and we must all take off our hats to Sir William, for he has given of his means very, very lavishly for the sanatoriums of which he is the honored head, and given of his energy and his time to an incomputable extent.

Only a few short years ago did we sorrowfully chronicle the burning of the Sanatorium at Weston, one of Sir William's monuments; and within the past year we recorded the disaster by fire of the Essex Sanatorium at Kingsville.

This journal more than once has strongly advocated that *all sanatoriums and hospitals be fire-proofed*. That is safest and cheapest in the long run. Better not build so large, and use cement or steel and reinforced concrete instead of wood.

In those institutions for the sick already built and in use, every precaution should be taken to prevent fire and every means employed for coping with fire should it occur. The sprinkling system, a good fire alarm system, hose and hydrants (frequently tested), hand grenades everywhere, tanks of water placed in many convenient places, buckets of sand, and every and all devices for coping with an outbreak.

Fire drill should be carried out weekly. Every official about the place should have his post—one to turn off the gas at the main, another to turn off the electric current, others to man the hose pipes, others to handle buckets or fire extinguishers, and others to remove patients—all without hurry or flurry.

We sincerely hope that not many months will elapse until fireproof buildings at Gravenhurst are erected to take the place of those destroyed. And we hope Sir William Gage may be spared many years yet to minister to the thousands of our fellows in the province who are or will become victims to this fell disease.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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Original Contribution

BETTER HOSPITALS

J. N. E. BROWN, M.B., TORONTO.

REV. FATHER MOULINIER gave an address to the doctors, sisters and nurses of St. Michael's Hospital on Nov. 27th. His Grace Archbishop McNeil was an interested listener. When the writer of these lines arrived the speaker was saying that the Council of Medical Education engaged in estimating the hospitals of the States from the point of view of the interne, considered that if a medical man gets 100 per cent. modern medicine some time in his life, 20 per cent. he acquires at the school and 80 per cent. afterwards. It was inevitable that the medical profession of the States should turn its eyes towards the hospital. Hence there was printed a list of those hospitals which were places for real scientific internship. Some six years ago the American College of Surgeons came into existence—a body of the leading surgeons. At first there were gathered men of the most unquestioned reputation as the leading surgeons. Some 500 gathered in Washington as charter members of the college, which now includes 4,000, with a waiting list of 15,000. It is as much a Canadian as a United States body. This present year they have taken in members from South America. We may look forward to a real full American College of Surgeons.

These 500 charter members, at a banquet, the speaker was told, had proposed to them this question: Why have you organized? Is it to get together once a year to partake of an elegant banquet, sound one another's praises and go back each to his respective home and live on the flattery that was meted out freely? Their immediate answer to that question was, No. The reason for our existence is to try and do something on this continent. Being patterned after the Royal College of Physicians and Surgeons in England, they said, we have a mission to perform. We know that there is incompetent surgery and malicious surgery going on all over this continent; there are men practising surgery not qualified, practising merely for

money; go into it before becoming fit, and keep at it in spite of their incompetence. These charter members of the College of Surgeons said: We owe it to the public to protect them against all this wrong surgery. It was clear to anyone who knew anything about the situation that this could not be done without entering into the work of hospitals, because it is in hospitals most of the surgery is performed. Hence they secured the services of Dr. Bowman (a layman and Ph.D.), who, after gathering much data from Canada and the States, undertook to make a preliminary survey of the hospitals of the continent. After having another large meeting in Washington a few months later, he paid a visit to the Surgeon-General's office to get all the information about what is indispensable fundamentally to a proper hospital service, and after calling in experts from all parts of the continent they formulated what they now call a minimum standard of hospital service.

Just about this time I had the good fortune to have thought of forming an association of Catholic hospitals. Having been connected with a medical school for some years I saw very clearly that medical students would not be taken proper care of after leaving the schools unless something was done with the hospitals. I looked up the list of Catholic hospitals and found there were 650 in North America. A meeting of representatives of these was called in Milwaukee six years ago. We had represented 52 hospitals—103 people, sisters mostly, a few doctors and a few nurses. Last June we had a meeting in St. Paul. There were in attendance for three days between 700 and 1,000 sisters, 50 or 60 doctors, a fair number of nurses, and some 20 or 30 clergymen. The investigation of the American College of Surgeons showed that these 650 hospitals conducted by the sisters have about one-half the bed capacity of all the general hospitals of our northern continent.

When they started their work of standardization actively, carrying all through the country their propaganda for a better hospital service, Dr. Bowman, along with Dr. Franklin Martin, and Dr. Wm. Mayo and several others of the leading men of the American College of Surgeons, came to the conclusion that if they would carry on their work with satisfaction and as their

spirit prompted them to, they would have to have an agreeable and acceptable entry into the Catholic hospitals. So, Drs. Bowman and Mayo went to his Eminence Cardinal Gibbons and told him what they proposed to do; and got a letter of endorsement from him. Shortly after they came to me as President of the Catholic Hospital Association and asked me if I would join in with them in their effort to make hospitals a better place for sick than they had been. After consultation with the Archbishop at Milwaukee and speaking to my Superiors for leave, I got their permission to join hands with them most heartily, and ever since that time have been in close co-operation with the American College of Surgeons in the effort to make better hospitals. The word "standardization" has become a shibboleth. It means nothing more than trying to make better hospitals. The term minimum standard does not mean an arbitrary standard. The collective brains of the medical profession of Canada and the United States on the part of men who are supposed to be the leading thinkers in the matter have been employed—mobilized for the determination of what is called the "Minimum Standard." It is made up of three main points: there are three main requirements with a few others which are logical deductions or corollaries from these three. The first requirement is organization; the second is case records; the third is adequate laboratory service; the fourth is the declaration on the part of those who serve in the hospital that they will not participate in the secret division of fees in any form or case; the fifth is autopsies. These should be sought by concerted action in the case of deaths resulting from unknown or uncertain causes.

One sees clearly that such a programme is not one that requires large funds. It will cost very little to organize—in the way of money. It costs but little to institute records—a record room and a keeper. The laboratory may cost something in initial expenditure and will continue to cost if properly equipped and kept up to date and properly manned. Having members of the staff sign against secret fee splitting costs nothing. Getting autopsies costs very little, if anything. And so the whole programme is not one arbitrarily forcing upon

institutions a large outlay of money. It is a very exacting programme in so far as outlay of mental effort, determined purpose, high ethical standing on the part of the staff are concerned. It calls, therefore, for a type of man and woman in the hospital—it appeals to all that is best and deepest in us—scientific, ethical and religious; because it means unstinted effort to bring to every patient in the hospital, irrespective of who or what he or she is, as near 100 per cent. institutional medical service as the group of men and women in the hospital are capable of giving and can reasonably be expected to give. That is the soul and purpose of the minimum standard. I think that is the secret of its success. No body of men without legal binding, without any power except the power of the truth, could go over the continent and get the response that they have received unless they had a programme that is inherently true and right, appealing to the best minds and the best characters in the medical profession and having the approval of the managers of hospitals and nursing schools.

What do they mean by organization in a complex institution like a hospital? It means that the medical staff shall be so co-ordinated that within itself and with the managing personnel and the nursing division of the hospital that there will be sympathy and clear and sure functioning of the medical staff in its bringing to the patient and to every patient as near 100 per cent. of up-to-date institutional medicine as can reasonably be expected. The men themselves, therefore, must be organized. There should be departments covering the whole field of medicine, with a director of each department. There should be a president or chairman and secretary of the staff. There must be at least monthly meetings at which every member of the staff is expected to be present, for the purpose of reviewing the work of the hospital accomplished during the preceding month. Personally, I believe all the rest that is spoken of as part of standardization can be disregarded as far as effort and propaganda are concerned, provided you have this one feature working in an institution. Have a body of medical men working in a hospital—I don't care how many forms of staff or divisions of the staff there may be—there may be a

university division; an un-university division; there may be specialists; there may be a staff by courtesy (a visiting staff to whom is extended the privilege of bringing patients into the hospital); but it is essential that all these men meet at least once a month and ask one another—have brought before them—what the hospital has done during the past month with the patients who came to it.

The hospital patient in terms of modern medical thought is the institution basis of the medical group (call them what you will), with the nursing group, with the governing body of sisters or sisters and clergymen and laymen. The institution stands before the public as the place where the sick are cared for, where the sick are given every kind of the latest service known to the medical profession, to the nursing profession and to the hospital managers. If that is the kind of institution the hospital is, the public, the keen, observing, searching public will say to itself or may say to itself, has a right to say to itself, "If I go to that hospital I'm sure I'll get all that modern medicine, as known in this locality, can be given to me in the way of careful diagnosis, operation (if necessary) medical or drugless treatment (if necessary); and I feel I may put myself into it, where I can get all that I have a right to look for." If any shrewd business man in Toronto said that to himself and came to you here, approaching any one of the individuals concerned with this institution and said to you, "Is that the kind of institution St. Michael's is?" You would have to say you thought so; at least, you wanted it to be such, that you hoped it were such, because you couldn't say "Oh! no, that is not the kind of institution St. Michael's is. You go there and you'll get some service; may be all right, may be not; depends on the man in whose hands you fall, upon the nurses who take care of you. It will depend on many circumstances as to whether you will get this fine, complete modern up-to-date service." None of you would say the institution does not stand for that. You will be obliged to say to such a man—I conceive at least if you have been thinking along the lines of modern progress in regard to hospitals—"St. Michael's is one of the best hospitals on the continent; come here and you will get all you have the right to

expect: fine medical men (university men); best nursing school, a body of sisters unequalled. We are under the Archbishop and a Board of Directors, so come here and you will get as near 100 per cent. institutional service as any institution can give you on this continent." Of course, you will say that, you'll mean it and want it. I have every confidence in stating that every man and woman here believes it to be that kind of institution; if not absolutely, at least determined to reach that height of progress and service.

What I have said brings out this one point, which is fundamental: the whole movement of standardization is centred on the patient. The institution is not primarily for the medical profession. No hospital is. It is not for the nurses, or for the group of sisters, or trustees. But these three bodies have united together and are co-operating with one another—skilled workers, who are giving to patients everything the patient has a moral right to get. And it is to the credit of the College of Surgeons and to the leading men of the medical profession that they recognized this right. They realize that they have come into these institutions for their patients. They realize that hospitals are there for patients, not for themselves. There are many incidental benefits to all concerned; but the real soul, the centre, beginning and end of the hospital is the patient and the patient's moral right, a God-given right, as against the medical profession, nurses and managers; a right that has to be respected, that he get full satisfaction to that right. The obligation of all is that his right be met and served and answered. That being the case the prime function of the medical staff, the prime function of sisters and nurses is to know from day to day if possible, from week to week if possible, certainly from month to month—know they are giving the patients that kind of service.

How is that found out? By meeting together and by questioning the work of the hospital, questioning the output of the hospital—to use a word common in modern industry. How many patients have been admitted? How many have died? How many have been kept longer than they need have been? Find the facts and face them fearlessly is the alliterative way in

which the whole thing is formulated in my mind. Any group of men and women doing any work for human health who are not brave enough, morally brave enough, large enough in character, to face facts of their combined efforts as members of an institution, I claim are not fit to be in the institution and are untrue to their deepest obligation.

(To be continued.)

HONOR NURSE'S MEMORY

ON December 3rd a tablet in memory of Nursing Sister Lena A. Davis, who died while on active service overseas, was unveiled in the Western Hospital. Miss Davis was a graduate of that hospital in 1908, and the Alumnae Association is erecting the tribute to her memory.

At the outbreak of the war Miss Davis was the matron of the Hospital for the Insane on Queen Street, a position which she held for several years. She went overseas with the University Base Hospital unit which was sent to Saloniki, and it was while on duty there that she contracted malaria and was invalided to England. Although extremely ill and never fully recovered from the effects of the disease, Nursing Sister Davis went on duty again in England, at Basingstoke, where she died of black water fever in February, 1918.

Miss Davis' home was in Beamsville, where her mother still lives. A sister was for a number of years a member of the teaching staff of the city schools, but has since died.

The tablet was placed in the Assembly Hall of the hospital.

Canadian Hospitals

46TH ANNUAL MEETING OF THE TORONTO HOSPITAL FOR INCURABLES

At the forty-sixth annual meeting of the Toronto Hospital for Incurables favorable reports were presented on the general work of the institution, the death rate being the lowest for several years. There was an increase in the overdraft, but it was believed that this could easily be met if the deficit were made known. A feature of the meeting was the graduating of a number of nurses who had completed the three years' course in the training school.

The devotional exercises included the reading of the 4th chapter of the Epistle to the Philippians, followed by the Lord's Prayer, conducted by Canon Plumptre.

Mr. Ambrose Kent, chairman, paid tribute to the efforts of the board of management and the staff in making the hospital so efficient. He pointed out that in the past forty-six years there had been a marked development, the accommodation at that time being six beds, and at present 250 beds. Also it must be remembered by those engaged in the work of the institution that cheerfulness was one of the chief essentials for duties of so difficult and exacting a nature.

On behalf of the medical staff, Dr. W. H. B. Aikins reported that during the year 79 patients were admitted suffering from various diseases. Of these 49 died, one was transferred to the Hospital for the Insane, and 27 were discharged. On October 1st, 1919, there were 214 patients; on September 30th, 1920, there were 217 patients, and 293 patients were cared for during the year. The general health of the hospital, of both patients and staff, had been good. It was deemed advisable by the medical board to quarantine the hospital during the smallpox and influenza epidemics, in the Autumn and early Winter of 1919-20, with the result that there was very little acute illness, and the death rate was correspondingly low.

Miss Cook, the superintendent, presented an account of the year's work, giving in some detail the nature of the diseases from which the patients were suffering. Of the 293 who were cared for during the year 30 had to be fed three times a day, 55 were confined to their beds, and there were only 18 who required neither medical care nor nursing. There had been a marked decline in the number of cases of cancer.

In connection with the activities of the patients, she stated that prizes in manual training had been won at the Canadian National Exhibition and success was attending the efforts in basketry by the blind. Entertainments had been given by Creatore's band, the Salvation Army, the Ontario Motor League, and Thaviu's Band, and free admittance to the Exhibition had been granted the inmates of the hospital.

The Treasurer's report, which was given by Miss J. Z. Groat, showed an advance of 20 per cent. in the statement. Last year's overdraft had been \$9,395.10, and this year's \$12,094.55, making a total of \$21,489.65. Expenses had been \$142,003.10, and receipts \$129,908.55. There were at present 214 patients in the hospital, 103 men and 111 women. The death rate was lower than it had been for several years.

Mr. R. S. Gourlay, in moving the adoption of the reports, said that two points in connection with the work must be remembered, the happiness of the patients in the midst of great weakness and pain, and that in dealing with incurables a large measure of grace, patience and love was required, but that, "Inasmuch as ye do it unto one of the least of these, ye do it unto Me."

Board of Management are:—Mrs. Grant Macdonald, Miss Mortimer Clark, Mrs. J. P. Balfour, Mrs. A. Cowan, Mrs. Wm. Davidson, Mrs. S. L. Fountain, Mrs. A. Foy, Lady Hearst, Mrs. Stewart Houston, Mrs. Ambrose Kent, Mrs. Lauder, Miss Effie Michie, Miss Grant Macdonald, Mrs. Hugh MacMath, Miss J. M. McGee, Mrs. S. H. Thompson, Mr. Ambrose Kent, Lt.-Col. Noel Marshall, Mrs. John Macdonald, Dr. W. H. B. Aikins, Mr. W. A. Baird, Rev. Canon Bryan, Mr. John Firstbrook, Lt.-Col. Alex Fraser, Rev. A. Logan Geggie, Mr. S. B. Gundy, Ven. Archdeacon Ingles, Mr. W. G. Kent, Dr. Edmund

King, Mr. E. J. Lennox, Mr. R. Millichamp, Mr. J. O. McCarthy, Rev. Dr. Young, Mayor Church.

Lt.-Col. Marshall stated that in none of the institutions with which he was connected was the work being carried on more conscientiously than in the Hospital for Incurables.

At the graduation exercises Mrs. Ambrose Kent presented the gold medal to the winner. Miss Helena Hamilton and Miss Mortimer Clark presented the silver medals to Miss Isabel Hewitt and Miss Valma Irvine. Mrs. Cox won the prize for neatness of room and person. Those who graduated were Miss Irvine, Mrs. Cox, Miss Connell, Miss Hamilton, Miss Hewitt and Miss MacLennan.

Congratulating the graduates on their choice of vocation, Dr. C. J. O. Hastings spoke of the value of real service. To give even a cup of cold water would bring its reward. The work of the training school was outlined by Miss Cook, who said that the eight hours a day system was making an improvement in the general health of the staff. She referred with deep regret to the death of Miss Stewart, one of the nurses, and also to the parting with the graduating class.

LAST PATIENTS LEAVE SPEEDWELL HOSPITAL, GUELPH

WITH the departure of the last 54 patients for Toronto on November 8th, Speedwell Hospital, Guelph, Ont., was officially closed, only a small staff being left behind to wind up the affairs of the institution.

The party was bound for Christie Street Hospital, and was made up of 45 walking patients, nine stretcher cases, two doctors, seven nursing sisters, three vocational aides, and nine orderlies. They were in charge of Dr. Fallis, who has been Acting Medical Superintendent at the hospital since the departure of Dr. J. B. McMurrich, who was called away suddenly some time ago.

Speedwell Hospital, which has been operating for a little

more than three years, was opened in October, 1917, with Lt.-Col. T. G. Delamere, of Stratford, in command; Dr. G. N. Urie as Medical Superintendent, and Capt. J. H. Menish as Adjutant. In that time several hundreds of disabled soldiers who fought for King and country, passed through the institution, while others who suffered more serious ailments through the effects of the hard life at the front succumbed while under treatment.

The hospital has meant a lot to the city of Guelph, and citizens generally are sorry to hear of its closing. Until two months ago the institution had some 300 patients housed within its doors, but since the recent trouble, which resulted in the dismissal of the entire nursing staff, prospects for the continuing of the hospital began to fade until finally the Government made the announcement that the hospital would be closed.

A pleasing event took place before the patients left, when the boys presented Capt. the Rev. S. E. Lambert, the Hospital Chaplain, with a purse of gold as an appreciation of his faithful services in their interests. Capt. Lambert had always been a favorite with the patients, and although he was not able to accompany them he expects to be transferred to Christie Street Hospital, Toronto, before long.

No announcement has been made as to the future use of the buildings at Speedwell, but it is expected that the Government will take some action soon. In the meantime the affairs of the hospital will be wound up, after which the majority of the staff will move on to London with F. Unit Headquarters, which is being transferred to that city.

HOSPITAL NURSES AT PETROLEA GRADUATE

THE Charlotte Eleanor Englehart Hospital graduation exercises took place before a large audience on October 19th in Victoria Hall. Miss Wilson and Miss Park were the nurses who received their diplomas.

Short addresses were given by N. McDougald, Chairman of

the Board, Dr. C. O. Fairbank, G. G. Moncrieff, Rev. J. Yule, J. L. Englehart and the Mayor. Wm. Pratt, Secretary of the Board, read the annual report. Miss Hickson, the matron, and her staff of nurses were presented with beautiful bouquets by Mr. Englehart.

During the afternoon a reception was held at the newly-erected Nurses' Home, the erection of which was the outstanding event in the year's development of the hospital. Its equipment will cost about \$65,000, all of which amount being donated by the founder of the institution, Mr. Englehart.

The proposed new work on the hospital building for the coming month is the erection of an additional wing which will accommodate eight beds; this will cost approximately \$15,000, and will be an added gift by Mr. Englehart. The operating wing and electric elevator are new features that are near completion.

The origin of this ideal hospital was a kind impulse of the late Mrs. Englehart, whose name it bears, who some ten years ago suggested the gift of the family residence and surrounding grounds of 40 acres for this purpose. Following up the original gift, Mr. Englehart has been most generous in his donations for its enlargement and its efficiency. Grants are made annually to its maintenance by the town of Petrolea, and also by the County Council of Lambton.

THE PLANT HOSPITAL OF THE GILLETTE SAFETY RAZOR CO. OF CANADA, LIMITED

It is a recognized fact that industrial efficiency is in a great measure dependent upon the health of the worker, for although great strides have been made in manufacturing processes, the utmost output cannot be maintained unless the operator is able to stay with the job. With this in mind our corporation equipped a hospital at a central point in the plant, and placed same in charge of a graduate nurse with one assistant. The head nurse examines all female applicants for positions, and thus they become acquainted with the hospital from the

moment they enter the plant. In her first interview she explains to them just what is done for the employee and encourages them to make full use of the facilities provided.

The hospital is equipped primarily to handle minor accidents and first aid work on the more severe cases, but a large amount of lost time is avoided by the preventive work carried on. All visits to the sick-room are recorded on a daily report and this is forwarded to the employment department, so that employees who are not of the required health standard may be eliminated, and those unable to stand certain classes of work transferred to more suitable employment. In addition it enables the employment department to follow up accident cases and make suggestions to the Safety Committee to prevent recurrence of such accidents. The varied nature of the cases will be seen from the following summary of one month's activities:—

Colds, 73; dental trouble, 28; headaches, 148; sore throat, 18; coughs, 5; sent home, 10; boils, 6; burns, 23; earaches, 4; indigestion, 23; sprains, 20; sent to doctor, 4; abrasions, 5; minor incisions, 319; eyestrain, 5; neuralgia, 7; nausea, 3; home calls, 5; bruises, 5.

An average of from seven hundred to eight hundred cases are handled per month and our absent employees do not amount to more than one and a half per cent. of the total number employed.

A dental clinic is held two mornings per week, teeth are examined and instructions given in the care of same, minor extractions and temporary fillings being made free of charge. The dentist fills in an examination form showing work required to be done and an estimated cost of same. If the employee wishes to go ahead with the work, he or she takes this form to the employment department, where terms of payment are arranged consistent with the worker's ability to pay.

In addition to the work outlined above, all employees who are absent from work more than three days are visited in their homes and a report made to the Company's physician of all cases requiring his attention. Our experience shows that our hospital is of vital importance and beneficial to both employer and employee.

GUELPH TO HAVE INSANE ASYLUM

SPEEDWELL Hospital, formerly the Ontario Reformatory at Guelph, is being restored after occupation by the military authorities, and on completion will be used by the Ontario Government as a central institution for housing the criminal insane. The intention of the authorities is to make this institution a rival of the famous Matteawan Asylum in New York State, which became famous during the incarceration of Harry K. Thaw. During the tenure of its military occupancy all the steel bars and grills were removed from the cells and windows to dispose of the prison effect, but, on account of the new use which it is proposed the building shall now be put, such safeguards will be necessary. The cost to the Federal authorities will be considerable, and it will be some time before the building is turned over and available for the transfer of inmates from other institutions in the Province.

All the military patients have been removed to Christie Street Hospital, Toronto.

PLANS TO HELP WEAK MINDED

PERHAPS no phase of public welfare is more vital to every other than is that of mental hygiene, which has made amazing strides since the organization, less than three years ago, of the Canadian National Committee for Mental Hygiene. The most recent piece of work done by this committee has been the making of a mental hygienic survey of the Province of New Brunswick. This study was requested by the New Brunswick Government, and included an investigation of 18 institutions caring for insane, feeble-minded, delinquents, dependents and unmarried mothers, together with a mental examination of 3,000 children attending 11 representative schools.

The survey was made with the purpose of determining the nature and extent of the problem of mental abnormality in New Brunswick, the present facilities for dealing with the situation, and the needs for the future.

New Brunswick is one of no fewer than seven Provincial Governments that have called upon the committee for assistance along these lines.

In many instances the advice of the committee has been accepted, and two Provinces are spending one and a half million dollars on mental hygiene activities. This means that more adequate facilities for scientific treatment of cases of mental abnormality have been provided, more preventive measures adopted and more humane custodial care supplied for those who must be kept confined.

The Federal Government also has officially requested the services of the committee in helping to evolve a policy in connection with mental abnormality, which will take into consideration prevention, early treatment, scientific treatment of pronounced cases and supervised parole of those who are recovering.

Since its organization three years ago the committee has inspected, outside of Toronto, 36 Provincial and county asylums, 20 jails, 17 industrial schools and 11 homes for dependents. This inspection involves a complete mental examination of all inmates, with the making of all necessary tests. There also have been 2,405 children attending private schools, 5,500 immigrants and 350 unmarried mothers examined. The findings have been presented to the Governments concerned, with many much-needed changes resulting.

The committee has laid great stress on immigration, and is satisfied that the Federal Department of Health is handling medical affairs in an efficient way with the equipment at hand. For the first time in Canadian history physicians trained in psychiatry are inspecting immigrants at ports of entry, and in the last few months have rejected many who are mentally unsound.

Arrangements are now on foot for the erection of several psychopathic hospitals in various parts of Canada. These institutions will accept early cases of mental disease as freely as general hospitals admit those suffering from physical ailments. Patients will be observed and treated for a limited period, and the experience of the Winnipeg Psychopathic Hospital shows that over 80 per cent. can be returned to their own homes. Such

treatment obviates the necessity of sending many to Provincial mental hospitals, with the consequent distress to relatives and friends.

Gifts to the amount of \$91,000 have financed the work of the committee for the past three years. Its budget for the next three years calls for \$135,000, for wider fields are opening up all the time, and the committee sees very much to be done before Canada can be safe from the dangers involved in neglect of this matter.

NURSING MISSION HOLDS THIRTY-FIRST ANNUAL MEETING

THE thirty-first annual meeting of the Nursing Mission was held on November 24th at 55 Beverley Street, Toronto, the home which was the gift of the late Dr. Goldwin Smith to the Mission for the period of its existence. During the past year the Mission has been so fortunate to have as its President Miss Snively, the former Superintendent of the Toronto General Hospital, and the reports given at the meeting contained a record of the accomplishment of the Mission's object, which is the nursing of the sick poor in their own homes.

Miss Helen Scott, in her Secretary's report, told of the work during the past year, when 811 patients were treated, 68 of them free of charge. Maternity nursing is one of the special works of the Mission, and not one life was lost. There have been seven nurses engaged in the work, and it was announced that Miss Hudson, who received her certificate on Nov. 24th, will remain on the staff. Miss Scott explained that as it is primarily a medical mission the workers are closely in touch with the Social Service Commission and overlapping is avoided.

The return of the former Superintendent, Miss Tolton, to the Mission during the past year was commented on with pleasure. The financial statement, given by Mrs. W. T. Ramsay, showed receipts amounting to \$5,275.74, and disbursements of \$5,169. Among the large donations during the year was one of \$250 from the Havergal Coverley Club.

HUMANITY IN HOMES FOR THE AGED POOR

At the convention of the managers of homes for the aged and infirm held in Hamilton on November 23rd, J. B. Reynolds, of the Huron County House of Refuge, deplored the fact that so much attention was given to the economic management of such institutions. What was essential was the human note—a spirit of kindness.

“In Huron we look on all our inmates as our own flesh and blood,” continued Mr. Reynolds. “They are all human tragedies. They respond to kindness quicker than children do. None of us but might some day have to enter a home for the aged and infirm, just as they have done. They are not paupers; they are our venerable elders on whom fortune has frowned.

“They take pride in their work. We make them feel it is their home, and, what is more, we feed them on the best we can possibly procure. The result is we are a happy family.”

J. B. Bates, Superintendent of the Wentworth Home for the Aged and Infirm, pointed out that of the 123 inmates housed there only 29 were born in Wentworth. The remainder had to be maintained by Wentworth regardless of the fact that they came from other municipalities.

I.O.D.E. PREVENTORIUM HAS GOOD YEAR

At the seventh annual meeting of the Board of Management of the I. O. D. E. Preventorium, a most satisfactory report was presented. During the year the new babies' pavilion had been completed, with accommodation for 50 babies. It is beautifully equipped throughout, with everything tending to the betterment in health of the little ones. The nurses' residence had also been completed and was a great source of comfort.

One hundred and eight children have passed through the Preventorium during the year. A great gain in weight and improvement in every way was reported in the case of every child. There had been very little illness, with the exception of

a few cases of measles and whooping cough, these being the diseases most dreaded with the children. No ill-results followed, however, nor complications of any kind.

The Honorary Treasurer, Mrs. John Bruce, presented a satisfactory financial statement for the year, showing that the receipts and expenditures for maintenance, furnishing and equipment amounted to about \$24,000, leaving a small deficit.

The sum of \$74,600 had been spent in the building of the babies' pavilion and the nurses' residence.

Gratitude was expressed to the Alexandra Rose Day Committee for the splendid contribution of \$6,500 from the proceeds of Rose Day.

The officers of the Board of Management were unanimously re-elected: Honorary President, Mrs. A. E. Gooderham; President, Mrs. E. F. B. Johnston; Vice-Presidents, Mrs. W. R. Riddell, Mrs. T. J. Clarke, Mrs. J. D. Hay and Mrs. Edmund Bristol; Honorary Treasurer, Mrs. John Bruce; Recording Secretary, Mrs. W. B. Maclean; Corresponding Secretary, Mrs. A. E. Wells.

THE HOSPITAL FOR SICK CHILDREN TRAINING SCHOOL

EXTREMELY happy were the graduation exercises at the Hospital for Sick Children Training School, on November 19th. For, as Mrs. Ferguson Burke reminded the big class in her felicitous speech in presenting the diplomas, they had the unique honor of graduating in the year of the Florence Nightingale Centenary, whom they should take as their patron saint. While for their valedictory message this year's graduation class had no less a person than Matron-in-Chief MacDonald, who had headed Canada's nurses in the great war.

"Always remember that the mission of nursing is a divinely appointed one, adopting which you are consecrated to the service of humanity," said the evening's speaker.

Matron-in-Chief MacDonald congratulated the class on having crossed their Rubicon. They were now to add strength and

fresh courage and advance work their predecessors had been carrying on. Their degree must not be accepted as ending their training. Their education had just begun. Knowledge was power and success depended on preparation.

"Be animated by the spirit of service rather than money reward. Happiness is not settled by the coin of the realm. Line your pockets with cheerfulness," was Nurse MacDonald's behest.

The evening's speaker pleaded with the graduates not to develop a distaste for private nursing. It had many advantages. Again, they must act as propagandists to encourage more applicants in training schools. "You must be recruiting agents and see to it that your place here is filled by a probationer."

Matron MacDonald warned the class to have a hobby; not to be interested in some other thing than their own occupation made one stodgy. Keep up an interest in your sports and recreations, was her behest.

From her experience overseas, Matron MacDonald had no fear that the new graduates would not uphold their best traditions.

"You shall not fail to hold the lamp so high," said Matron MacDonald, who concluded by giving the class her best wishes that they might have plenty of work, plenty of play, "in each of the kinds you like best."

Miss Potts, in her superintendent's address, pointed out how the Training School had continued its usefulness to the hospital and community. Its ability to realize the importance of educational attainments has drawn to its doors those who might well be considered fitted for the high places in life and its work. That they were so fitted has been demonstrated by the positions they have maintained since their graduation.

"It is more than merely interesting," said Miss Potts, "that we have in our Training School a group of young women, who, with their substantial academic foundation have acquired their nursing skill and knowledge and are anxious to continue their education along nursing lines.

"Ten of the present graduating class applied for scholarships to enable them to take the course in public health nursing

at the University of Toronto, and three for the teachers' course given at McGill University.

"It is to be regretted that we have been unable to assist a larger proportion of those applying for scholarships, since the demand and need for nurses with a broader education is so great.

"On the other hand we have been singularly fortunate, and are profoundly grateful to the following gentlemen, who voluntarily offered substantial scholarships: Sir Edmund Osler, Chairman of the Board of Trustees, \$500; Mr. H. H. Williams, trustee, \$350, and Dr. Alan Brown, physician-in-chief, \$350.

"Sir Edward Osler's scholarship has been awarded to the nurse who wishes to qualify as nurse instructor, this course being obtainable at McGill University.

"Mr. Williams' scholarship has been awarded to one of the nurses whose desire it is to take the course in Public Health Nursing at the University of Toronto, and Dr. Alan Brown's scholarship is also awarded for this course, with the idea of developing the child welfare aspect of the work.

"It is very gratifying to know that these special courses may now be obtained in our own Canadian universities. Heretofore many of our best women were compelled to continue their education in the United States, resulting in their services being entirely lost to Canada.

"Within the last week ten graduates of this school applied for registration in the State of New York. This, I think, emphasizes in a small way the importance of the development of our educational machinery where the need for our own Canadian nurses is so great.

"We have again accepted a scholarship nurse from the Vancouver General Hospital for six months' post-graduate course, which shows the widespread interest and the importance attached to children's work.

"It is possible to do more for the school in the future, and if we are to keep pace with the times and maintain our high standard of efficiency, more accommodation must be provided for pupil nurses, so that the nursing staff may be increased to

the extent that will make it possible to introduce the eight-hour day and meet the ever increasing demands upon the school.

"The past year has been no exception to those that have gone before in the matter of applicants to the Training School, certainly there has been no diminution in numbers.

"The enrolment in the school at the end of the year was: twenty-two third year pupils, twenty-one second year pupils, twenty-six first year pupils, twenty probationers and sixteen pupils from affiliated schools."

Miss Potts paid tribute to the spirit of the student nurses, and the school's gratitude to Dr. Graham, Dr. Hannah and members of the surgical staff.

Dr. Alan Brown gave a most interesting sketch of the rise of the public health nurse and her possibilities in the future. He also quoted Disraeli's dictum that the first duty of a statesman was the cause of public health.

After the closing exercises the guests adjourned to the reception rooms which were massed with the nurses' bouquets. As rosy pink as their friends' best wishes were most of this year's blossoms. In the big hall were more pink roses.

Bowls of them had been placed beneath the portraits of Maria Gillbee Robertson and the late John Ross Robertson, the latter presented by his son, Irving E. Robertson.

FIRE AT MUSKOKA FREE HOSPITAL FOR CONSUMPTIVES

Two hundred and sixty patients in various stages of illness were asleep in the Muskoka Free Hospital for Consumptives when fire destroyed the main buildings in the early hours on November 30th. Shortly after midnight Nurse Edith Hall, who was on night duty, discovered smoke near the ceiling in the upstairs kitchen of the main building, although no fire was visible. Suspecting defective wiring hidden behind the plaster, she gave warning and efforts were at once made to remove the patients in the building to other quarters. One of the care-

takers in the building was immediately on the scene where the smoke was issuing and the emergency fire hose arrived on the spot only to discover that there was not water pressure enough to reach even the ceiling of the room. In the meantime the furniture was being removed, while the fire gained headway.

A flare of lurid light leaped from under the eaves and from that moment until three o'clock in the morning, nearly three hours, the beautiful modern frame buildings one after another fell prey to the roaring flames.

During all these three hours, no water was available until the arrival from the neighboring town of Gravenhurst, two miles away, of a pumping engine which was placed on the wharf and pumping water from the lake, was soon providing a pressure that brought the fire under control.

The electric pumping apparatus which supplied the sanatorium tank reservoir was useless as soon as it was necessary to shut off the electric light, as the light and power plant of the institution were all on one switch. Only the fact that it was a very still and mild night saved suffering by exposure and slowed the development of the fire, giving adequate time for rescue, or the experience of the night might have been fraught with fatal consequences.

Over a hundred of the worst cases in the infirmary had to be twice removed from buildings in the path of the flames. It was a pitiable sight to see a great hospital population out doors with a background of snow and fierce flames, but the sufferers were marvels of bravery and good cheer, and although many lost their possessions no word of complaint was heard from the lips of the sufferers.

DROPS HOSPITAL PLAN

THE project for a \$2,000,000 hospital in Hamilton as a war memorial has been dropped and the ratepayers will be asked to vote on whether they wish a hall or a monument as a memorial.

TORONTO'S HOSPITAL NEEDS

HAVING visited many cities in the United States, the Committee appointed to go into the question of hospital accommodation, as it affected Toronto, has some interesting things to say in its report concerning conditions in other cities.

Dealing with Detroit, the report sets out that infectious disease cases are cared for in an isolation hospital under the control of the local Board of Health. Provision has also been made for the care of 200 beds for tuberculosis cases. In addition a new tuberculosis hospital has been constructed on about 800 acres of land situated about twenty-five miles from Detroit to deal with incipient or moderately advanced cases.

Detroit uses both municipal and private institutions in caring for its indigent sick. The Department of Public Welfare has in the downtown district a municipal hospital for 500 patients. Detroit pays \$16 per week for patients placed in private hospitals by the city. A hospital inspector sees the patients at these hospitals and reports on social conditions, and on these reports is based the decision whether he or she is an indigent case. Chronic or incurable cases are discharged to their homes. Plans for a Municipal Hospital to care for 1,000 patients are being prepared at the expressed wish of the citizens. At present the police stations are used as health centres.

In Cincinnati, the committee found that the principle of municipal hospital maintenance had been in existence nearly a century. Their present hospital accommodation was for 850 patients. The Isolation Hospital Management is not under the Local Board of Health, but is under the jurisdiction of the General Hospital Superintendent. There are no pay or private or semi-private wards in the General Hospital, and only those who are unable to pay their hospital rates are taken in and cared for. Notwithstanding the care taken to prevent it, over \$40,000 is spent every year for upkeep of patients, who get in, and who really have no claim on the city. In 1919 the total cost of the hospital was \$456,929.

In Washington, D.C., the committee discovered that plans were already under way for a municipal hospital for which

the contract price was \$3,750,000. Mr. George S. Wilson, an outstanding authority there, said that the civic hospital should be a teaching school.

In New York opinion favored both municipal and private hospitals. Dr. Goldwater was against drying up the streams of benevolence entirely. "It is interesting to note," he says, "that fifty-five per cent. of the accommodation is within half a mile of the centre of population, sixty-six per cent. within one mile, and eighty-four per cent. within a mile and a quarter."

The report next deals with the present hospital accommodation in Toronto, quoting the Medical Officer of Health, who favored centralization from a teaching and specialist's point of view. He gave the number of beds in the various hospitals as follows: Toronto General, 780; St. Michael's, 313; Hospital for Sick Children, 250; Wellesley, 80; Isolation, 300. This means that seventy-eight per cent. of the hospital accommodation is east of the centre of population, and only twenty-two per cent. west. If they deducted the Isolation Hospital the percentages are seventy-five and twenty-five per cent.

COMMITTEE FAVORS A MUNICIPAL HOSPITAL

A LONG and exhaustive report of the committee appointed to go fully into the question of the needs of Toronto from a hospital standpoint including the requirements of Riverdale, was recently presented to the Board of Control. The committee was composed of the Medical Officer of Health, Finance Commissioner, Ald. Hiltz, Mayor Church, and Controller Cameron. Associated with them was a committee of five citizens from a deputation of ratepayers from the district east of the Don. The committee visited a number of cities across the line, including Detroit, Cincinnati, Washington and Boston.

Recapitulating their findings in these cities, the committee report as to the advisability of a municipality owning and operating its own hospital for its indigent patients, there was no

second opinion except that of the superintendent of Massachusetts General Hospital, that the consensus of opinion favored one central building or group of buildings as against separate units, that in a municipal hospital only public ward beds should be supplied, that the hospital should be a teaching institution in closest co-operation with the Medical College, that no city council should turn over any sum of money to a Board over which it has not complete control, and that there is room for both, but the private hospital should not receive any grant from the city.

Dealing with Toronto the general conclusion arrived at by the committee was that while it concurred in the general principle of municipal hospitals, yet after careful consideration it was forced to conclude that it could not but view with disfavor the whole public ward service or accommodation as conducted at present in both private and municipal hospitals.

As to the question of individual responsibility, the committee asked if a fire department were paid to protect property and a police department to protect lives and property, why not make similar provisions to protect the people against the ravages of disease? There was no stigma of charity in connection with the boys and girls attending the public schools. Why should there be any in their being treated free in a public hospital? An appalling number of cases had been allowed to go until they were incurable owing to the lack of means and an unwillingness to apply for a hospital order.

Finally the committee recommends the adoption of the principle of municipal hospital control, and that the city proceed at once to secure a site, having in view the establishment thereon of municipal hospitals, and that they proceed to forthwith erect on the aforesaid site a convalescent home, which would ultimately constitute a part and parcel of the whole municipal hospital scheme, and, furthermore, that in view of the city's handing over every year approximately a million dollars per annum to the hospitals over which they have no control, for the maintenance of indigent patients, that a Hospital Commission be appointed forthwith, the personnel of which would enable the city to exercise reasonable control over the expenditure of the funds granted.

Book Reviews

A Short History of Nursing. By LAVINA L. DOCK, R.N., Secretary, International Council of Nurses, in collaboration with Isabel Maitland Stewart, A.M., R.N., Assistant Professor, Department of Nursing and Health, Teachers' College, Columbia University. New York: G. P. Putnam's Sons, Publishers, 1920. \$3.50 net.

This new volume has been prepared especially for the use of pupil nurses. It is a condensation of the *History of Nursing* by Nutting and Dock. The subject is presented in a concise and interesting manner, and the volume should fill an important place in the education of pupil nurses. In the opinion of the reviewer, however, too scant attention is devoted to some of the excellent training schools in connection with certain hospitals in Canada, where the entrance requirements and standards of teaching are unsurpassed anywhere in the world.

A Pocket Medical Dictionary giving the pronunciation and definition of the principal words used in medicine and the collateral sciences, including very complete tables of the arteries, muscles, nerves, bacteria, bacilli, micrococci, spirilla, and thermometric scales and a new dose-list of drugs and their preparations in both the English and metric systems of weights and measures, based upon the ninth revision U. S. Pharmacopeia, also a veterinary dose table, by GEORGE M. GOULD, A.M., M.D. Eighth edition revised. 40,000 words. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1920.

A new English-Chinese Lexicon published by Dr. P. B. Cousland in Shanghai for medical missionaries, is largely based on Gould's Medical Dictionary. A nice compliment. Medical men could find certain office leisure well spent in conning over this fine little volume.

Care and Feeding of Infants and Children, by W. R. RAMSEY.
Second edition. Philadelphia and London: The J. B. Lippincott Company. Price \$2.50.

This is a very good little text-book for nurses, trained or "experienced." It is simply and plainly written, and is practical, giving briefly the sort of information which is useful to a nurse. The chapters dealing with the general care and feeding of children—the preventive medicine part, which is of such paramount importance—are good. The anatomy and physiology have been considered only in so far as they relate directly to the subject of child welfare, and rightly so. Too much of the undergraduate nurse's time is wasted nowadays in lectures on subjects which can be crammed for examinations and which are immediately forgotten, while too little importance is laid on the necessity of being able and willing to make patients comfortable. The discussion of the pathological conditions common to infants and children is brief, but fairly accurate and to the point. The illustrations are instructive.

Outlines of Nursing History, by MINNIE GOODNOW, R. N.
Author of "First Year Nursing," "Ten Lessons in Chemistry for Nurses," "The Nursing of Children," "Practical Physics for Nurses;" formerly Directress of Nurses, Milwaukee Country Hospital; formerly Superintendent of the Woman's Hospital, Denver, and of the Bronson Hospital, Kalamazoo; Specialist in Hospital Equipment. Second edition revised. Illustrated. Philadelphia & London: W. B. Saunders Co. 1919. Canadian agents, J. F. Hartz Co.

The contents of this book should be familiar to every graduate nurse and should be a part of the course of every nurse in training, for it sets forth clearly and yet briefly the development of this noble profession from earliest times up to the present day, and puts the reader on terms of familiarity with those great women who have had a share in developing the profession to its present high standard.

Of special interest is the reference to the development of nursing in Canada. The study of this volume as a text-book in a regular course of training will do much to keep before the nurse these high ideals which are the richest heritage of the profession to-day.

Helping the Rich. A Play in Four Acts. By JAMES BAY. Brentano's, Fifth Avenue and 27th Street, New York. 1920.

That it is up to the State to provide free hospitals for the poor and that people who can pay should pay, is the central theme of the play. It is also a clever little satire on conditions that are known to exist in large hospitals in regard to the politics that govern board and staff appointments. The play shows an intimate knowledge of institutional undercurrents. The repressive attitude of heads of medical services toward the younger aspiring members of the staff and the lack of professional camaraderie are cleverly touched off. A pleasant little love plot threads through the four acts. It brings a smile, and is most readable.

Pope's Manual of Nursing Procedure, by AMY ELIZABETH POPE. New York and London: G. P. Putnam's Sons. 1919. 596 pages.

This new volume sets forth in detail practical nursing and the method of teaching it. Although primarily a text-book for teachers it could be used with advantage as a text-book for junior classes because, not only are the demonstrations aptly shown, but the theory so important in carrying them out is set forth.

An exception taken to the contents is the chapter on restraint. This is unjustifiable in the present day of advanced medicine. It is most harmful to the patient and gives the nurse a wrong conception of mental disease. We now have hydrotherapy in the majority of our hospitals, and it will be found

that much good will be accomplished in resorting to this treatment, while the so-called restraint only works havoc. I, therefore, feel such a chapter should be excluded from a text-book to be used by pupil nurses.

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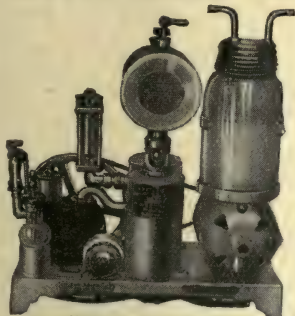
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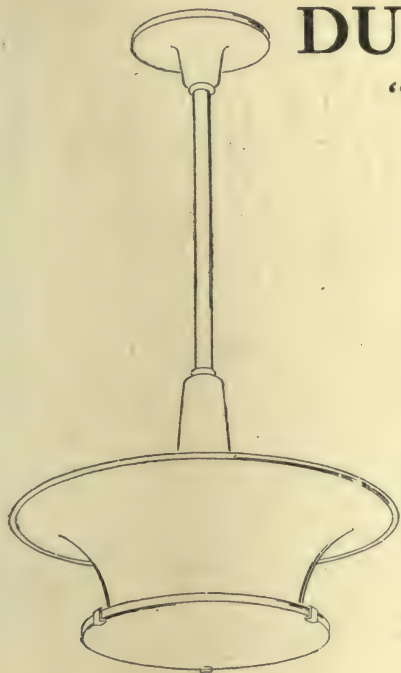
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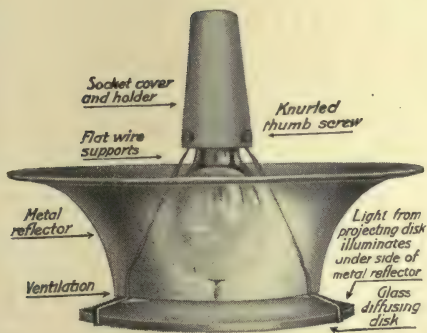
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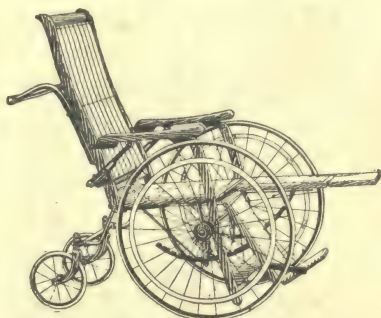
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Vol. XIX

Toronto, February, 1921

No. 2

CONTENTS

EDITORIALS

The Community Hospital	Page. 37
Co-operation in Buying	39

SELECTED ARTICLE

The Small Hospital or Sanatorium.	Page. 55
--	----------

HOSPITAL NEWS

ORIGINAL CONTRIBUTIONS

Better Hospitals. By J. N. E. Brown, M.B., Toronto	42
Calgary General Hospital	48
The Tuberculosis Situation in the City of Calgary	53

Grace Hospital Asks City to Wipe Off Deficit	62
Grey Nuns Want Hospital	63
Isolation Hospital Burns	63
Nurse Not Negligent	64
Notice of Extension of Partnership Amalgamation of the Montreal General and Western Hospitals ...	66
The New Whitby Memorial Hospital	67

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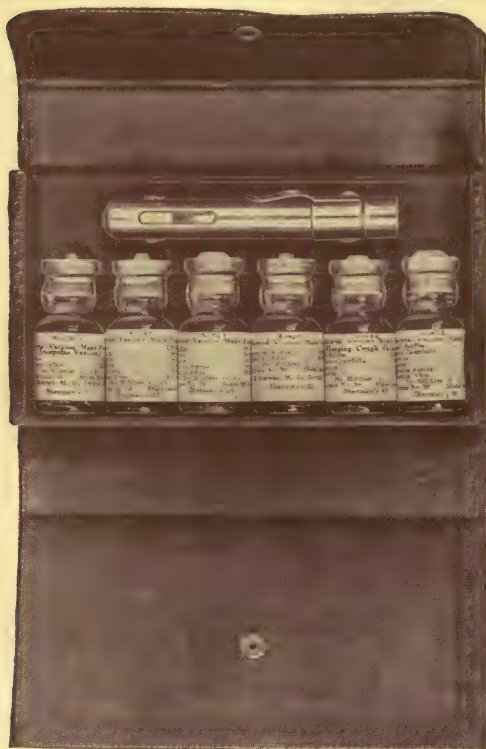
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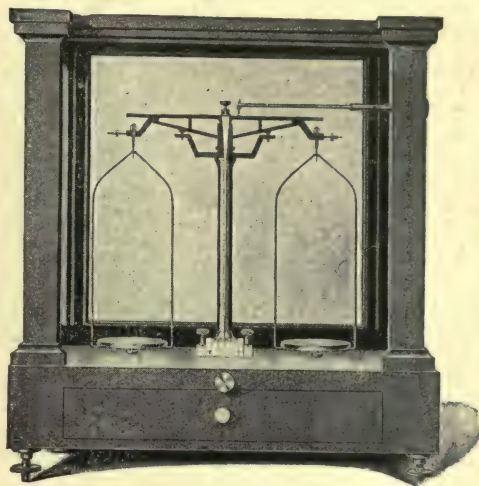
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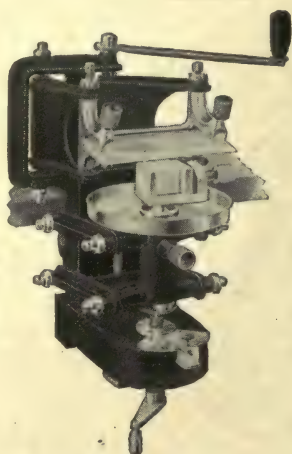


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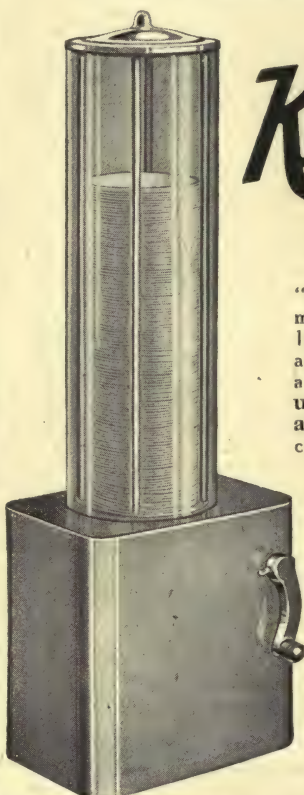
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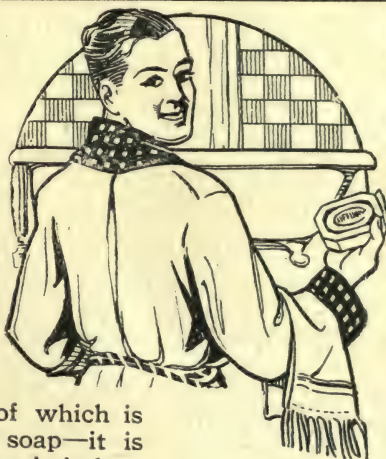
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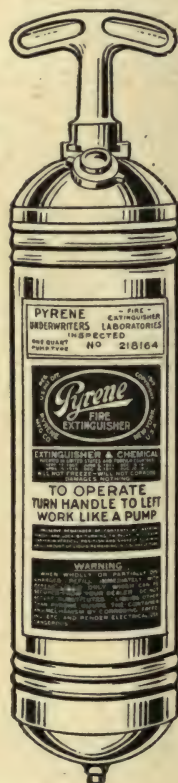
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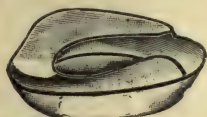
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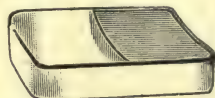
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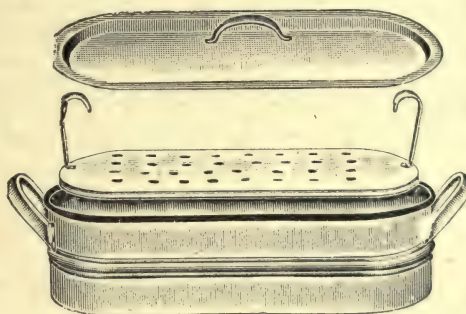
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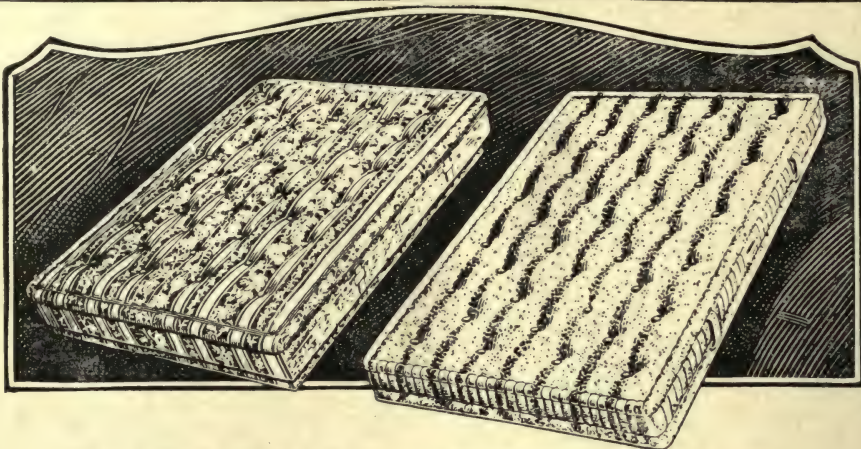
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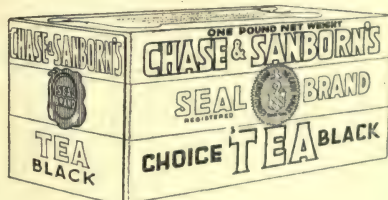
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WIRING WAS PRIMITIVE

**Proprietor of Hospital Says
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To Install Fire Es-
capes**

Ottawa, May 13.—(By Canadian Press.)—It has been decided to conduct a searching investigation into the fire which occurred early this morning at the private maternity hospital of Dr. F. C. Hagar, in which two patients lost their lives. The deputy fire marshal of Ontario, Mr. George F. Lewis, of Toronto, is in Ottawa.

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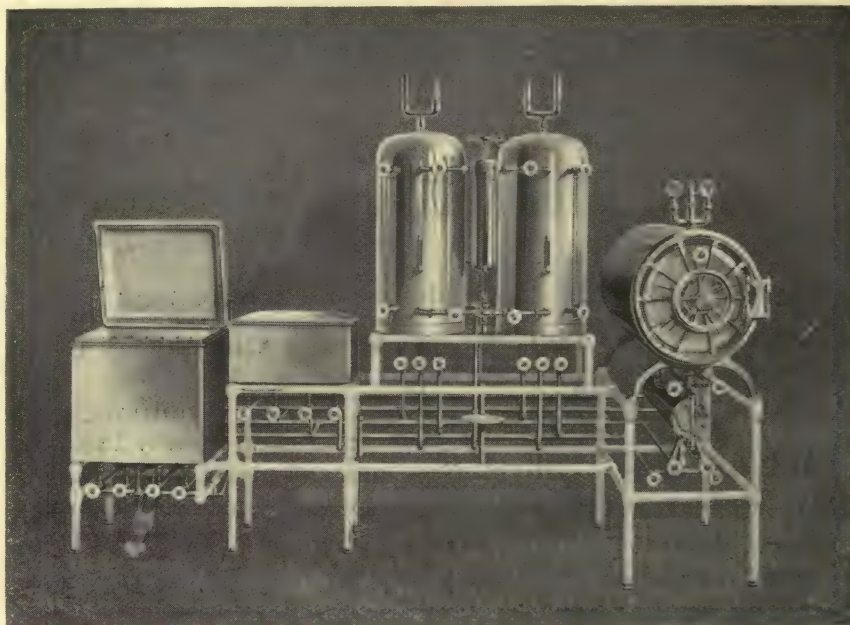
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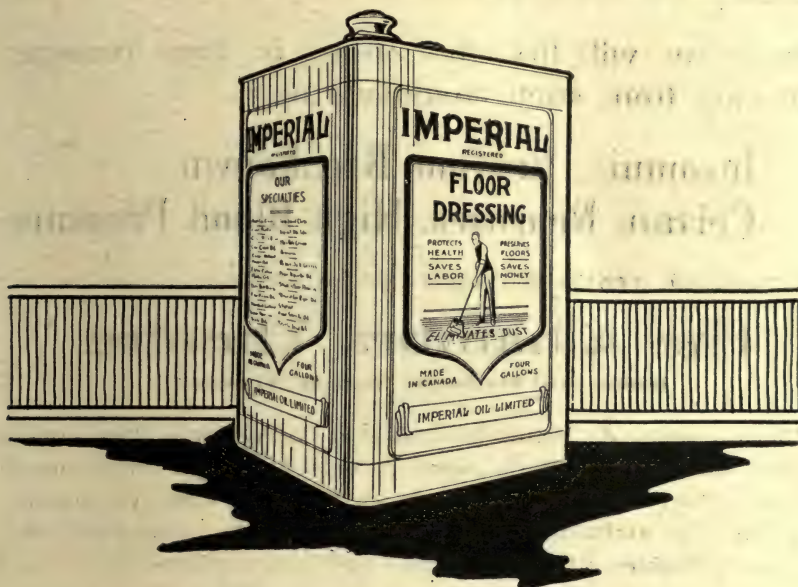
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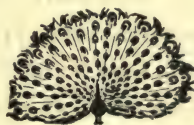
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The Hospital World

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and Public Charitable Institutions throughout the British Empire**

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Editorials

THE COMMUNITY HOSPITAL

DR. VICTOR VAUGHAN, one of the leading American physicians, recommends health community centres with a hospital connected with each. To make this possible he would pass legislation permitting any county or section of a county to constitute itself a health centre and to build a community hospital. The control of such a hospital should be under local direction, but with State supervision, in order to see that the work of the hospital is kept up to the standard. There should be in such a hospital at least one bed for every district. The hospital should be built and equipped and the salaries of the permanent staff paid by taxation of the people. A part of the tax should fall on the State at large, while another portion should fall upon the people of the community concerned. The hospital should consist of several units: (1) A general hospital; (2) A tubercular

pavilion; (3) An infectious disease pavilion; (4) A laboratory section; (5) A home for nurses. The staff of the hospital should consist of (1) The commissioner of health of the community, who would also be director of the hospitals and laboratories; (2) A surgeon; (3) An internist; (4) A laboratory man; (5) A certain number of trained nurses.

A lying-in room should be provided in the hospital, and there should be X-ray facilities. Such a hospital and all its facilities would be at the service of the people and of the practitioners in a community. A physician having been engaged to take care of a case of labor could, if he and his patient preferred, have his patient go to the hospital a few days before labor and there, in an aseptic room, and under aseptic conditions, and with facilities for any emergency which might arise, could conduct his confinement case. If a case of scarlet fever develop in a man's practice it could be looked after in the home if such were feasible, or it might be treated in the infectious disease pavilion under the family doctor's care.

Should a doctor have a case of laceration of the muscles of the thigh, he could take the patient to the hospital, where he would have an aseptic room for operating and where the surgeon of the hospital might assist him.

Swabs from suspected throats might be sent to the laboratory of the health centre, as also sputum from suspected cases of tuberculosis, instead of sending them to the State Board of Health.

If the local physician had a patient with any disease who needed a nurse, one of the hospital nurses might be called upon. If the patient were able to pay the nurse such payment should be exacted.

If the local doctor wished an X-ray, this might be taken at the hospital.

The community hospital should be under the charge of a local board, who would assess patients for hospital care according to the ability of the patient to pay.

An up-to-date diagnostic hospital is needed in every community.

CO-OPERATION IN BUYING

FIFTY hospitals and charitable institutions have for several years been buying through a central purchasing bureau. While many of these are in New York City and the New England States, the Grenfell Mission, Labrador, and the Hunan-Yale Hospital, Changsha, China, are members of the league. In a recent issue we recommended a single purchasing agent for all the Toronto Hospitals, which are now so heavily overdrawn at the banks. We think a purchasing agent or central purchasing office might do the buying for not only the Toronto Hospitals and charitable institutions, but for such organizations throughout Canada.

These institutions alluded to in the first paragraph call their joint venture a "Hospital Bureau of Standards and Supplies," and have as officers a

president, vice-president, a secretary-treasurer, and an executive committee of seven, six of their number being officers (usually superintendents) of the represented hospitals, the seventh being their purchasing agent. Two members of the executive retire in 1921, two in 1922, and three in 1923.

The bureau has 55 agreements for supplies in force. They find, as we suggested, that short term agreements show material advantages for dried fruits and canned goods. Bacterial counts and butter fat tests are made weekly—or oftener if necessary. Members of the bureau are kept posted as to prices and details, probable changes, deliveries and orders.

The agreements do not bind the members to buy, but it is the spirit of the organization that the selected suppliers shall be patronized. If the hospitals can do better elsewhere, the Bureau is notified, and after investigation, if a new agreement with a better source of supply can be closed, the former agreement may be cancelled.

If we remember aright this Bureau was established through the efforts of the American Hospital Association. Therefore we would suggest that the Canadian Hospital Association should be resuscitated, if for no other reason (there are many others—and good ones) than the formation of a Hospital Bureau of Standards and Supplies.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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Original Contributions

BETTER HOSPITALS

(Continued from January issue.)

J. N. E. BROWN, M.B., TORONTO.

IF my thesis so far is proven or acceptable to you, the next question is, how are you going to find the facts in regard to what the hospital has done for its patients? There is only one way. *There must be a record of all that is done for the patients.* They may be entered either by name or number. There are other things that for managerial purposes the first office must know, as a matter of finance and organization, but these are not the points the college is aiming at. The medical profession wants to know what you as doctors and nurses have done of scientific value in an institution for the care of human health. It wants to know what the patient came in for; what the patient thought was the matter with him. That is the starting point. That can be found out at the office desk by someone. The next step is a purely scientific step—to find out what you think is the matter with him—what is really wrong. Modern medicine is very different now from what it was ten, twenty or thirty years ago. We have improved in medicine to-day. To know the subject now means a knowledge of a group of sciences hardly known fifty or sixty years ago. A few leading men knew some pathology, some bacteriology and some biological chemistry—very little of that. Mere gross anatomy was known from the earliest days. Medicine up to recent years has been a mere empirical symptomological science. To-day it is something very different. Years ago there was a lot of mystery about medicine—superstition of all kinds grew up because people didn't know what these fearful diseases came from. Hence, in the olden time, a look at the patient, feeling the pulse, examining the tongue, a close, experienced glance at his complexion, the color of the white of his eyes, might have been enough, and

scientific, too, as grounds for a diagnosis. Old Hippocrates, the Father of Medicine, has left records of his time which are specimens—wonders of scientific record. The young lady in the office may do almost what was done by that great Father of Medicine. What she learns to-day—this lay admittance clerk—if she has experience enough—is about all that was learned by those splendid old practitioners of fifty years ago. To-day medicine is a very different thing, as we all know. We know to-day that there is an inheritance or heredity involved in the conditions: that is not very modern in reality, but it has become a matter of scientific formulation in connection with the personal history. The history of the condition in which the patient finds himself or is found is noted. John B. Murphy used to say that eighty per cent. of the diagnosis lay in a carefully made history. Therefore, with this knowledge of what the history means, the man to-day who does not make a thorough examination and record of his case is not practising modern medicine, is not giving the patient what he has a right to, is not using the obvious and fairly easy but, at the same time, quite expert, means of really discovering what is the matter with the patient. If I went to your record room and found very few histories; if I were to find there that an operation had been performed with no history, no record of physical examination, no laboratory tests and no preparative diagnosis, what conclusion would be forced upon me? That the man who had that case had not, or didn't care to use, or didn't care to regard the recognized means—the only means to make an operation a safe procedure.

To-day in any institution only an emergency—a pressing emergency—is the only excuse for an operation to be performed without a careful history and a careful physical examination—all the laboratory tests indicated, including an X-ray and a carefully-thought-out preparative diagnosis. After all, what is an operation? It is a mechanical procedure by which a surgeon hopes to remove something that is causing pain and ill-health to the patient. Would any of us be satisfied with the treatment he got if he were told by the doctor there was need of operation if he knew that the doctor had formed his judgment without using all means to make that judgment as

sure as modern medicine can make it? We would all revile such treatment, and rightly resent it; because the day of trial surgery, the day of mere empirical surgery, is past. The conscience of the medical profession disapproves of this sort of thing, because so many helps to diagnosis are available. Such a thing is looked upon as absolutely unprofessional, not to use a stronger word about it. Therefore, the conclusion is that unless the case is an emergent one, or so baffling that after the most thorough investigation has been made the best that can be done is to say, we don't know what is the matter; we think there is something wrong, and if you don't object we will do an exploratory operation. Short of these two, the duty now resting on the medical profession, whether surgery or medical treatment is involved, is to see that all the means which have been discovered through the growth of the fundamental sciences involved—bacteriology, physiological chemistry, pathology, X-ray, are used to find out what is the matter with the patient before doing anything for him.

This hit and miss procedure, so unscientific, this guess-work, the shrouding and beclouding of what is wrong with the patient, the day of this sort of thing is pretty nearly gone; I may say it has absolutely gone. . . .

There is nothing so inspiring to me as a layman, as the open-minded, above-board procedure of the leading medical men of our continent. They either know, or they don't know. The biggest of them, too, are first to say we don't know. And the larger and the greater the man is, the more ready he is to say I don't know. Groups of men working together in an institution will give the best of their specialized thought in trying to ascertain what is the matter with a patient, and still be unable to come to a conclusion. They say possibly this or that is the matter, and express a willingness to do what they can, but confess to the patient that as far as their knowledge goes they have not been able to ascertain exactly what is wrong.

Then out of the deduction, that every patient has a right to this step by step diagnosis, the staff conferences concur in the request made by a group of men working in the hospital that every man, no matter in what capacity, be brave enough

scientifically and professionally to stand up with his fellow professional men and face the facts as he has wrought them out, either with his personal patient or the ward patient.

I have often been told, after saying what I have, by medical men, that it is too much to ask of a group of medical men. Two years ago I was told on several occasions that it could not be done: "You cannot get the medical profession in any locality to face their own failures and reveal their own ignorance." I do not know whether or not it was too hard then. I know now it is not too hard. I know groups of men all over the country doing that very thing. I know they are the most satisfactory medical professional men on the continent, just because they are doing that thing. I know they are growing more rapidly than those who are not doing it. The reputation of their hospital has spread all over the country. This plan has been carried out at the Mayo clinic for years. Some of you have been there and sat at the weekly Thursday meeting where the failures at diagnosis and failures at operation are brought before the staff. I've been there, and I hope some of you have. And this thing is being done in other places. Everywhere it has been done there is the same satisfactory feeling, a feeling that used not to exist prior to these confessions and conference. It simply comes from doing their full, plain, manly, professional duty. They investigate their own work. They are seeing whether their hospital is doing what it professes to do for its patients—giving them real, genuine, up-to-date, combined, co-operative service. That is what they are doing—plain, simple devotion. It means work. You see it means concentrated thought and study; it demands a keen responsible professional conscience, demands not only that in the individual, but in the group. It means that no inefficient man, ungentle, can live in the atmosphere of that kind of institution. It demands that the incapable man will either get out or grow and take the means to grow. It means that he will learn what he is supposed to know. It means the growth of men mentally, ethically, scientifically and even religiously; because there is a certain consecrated devotion involved in that kind of staff service to the patients. And this spirit affects every person in the institution—every one will feel his sense

of personal responsibility. The nurses rise and develop into a conscientious body, individually and collectively, with a seriousness that is most stimulating. It is not unheard of in the past that nurses' charts didn't mean much sometimes—that they were unreliable, that things put down on the charts were not always credible. Under the new spirit, it means, where in the past there was group carelessness, thoughtlessness, a more or less light attitude towards the routine functions by nurses, a spirit of ambition to give the patient one hundred per cent. service. To the patient everything counts. A false temperature record, false pulse, a failure to follow out the doctor's orders or to modify them without his knowledge, may be of serious consequence.

If you, as a group of men, face the facts of your past month, your whole record is brought up in case of death, in case of a prolonged illness, and every fact in that record is looked at from the viewpoint of its influence on the welfare of the patient, so that the staff realizes its individual and corporate obligation, its influence reaches out into the whole hospital, and every move, every function gets a significance that in the drifting hospital of the past couldn't be looked for, couldn't be expected. Fifteen, twenty and thirty years ago, the hospital was looked upon by the general public, by the medical profession, by nurses, by sisters, managers and superintendent, by trustees, almost without exception, as a clean, kindly, helpful boarding-house for the sick. That concept of a hospital is utterly gone in the minds of the leading men in the medical profession, to the nursing profession and to those in touch with the movement for standardization. The hospital is an absolutely changed institution; it has to-day an institutional conscience, which means that every person working in it is keenly alive to a sense of responsibility to every patient.

RECORDS.

The records are the centre of it all. Records are hard to keep. Records demand labor. Records require of the medical profession their best concentrated thought. Records mean nothing unless there is back of each record, and of every part

of it, the signature of a responsible, educated, scientific, medical man. That means that every medical man must either write, or correct and revise, or read and o.k. and finally sign his record. Every hospital owes a record to its patients. It is the abiding statement or written voucher to the patient of what has been done in the hospital for him. It may be of very serious legal consequence to him and to the hospital. That is a minor consideration, however. It is due the patient because the hospital is a complex institution. Many things are done for him. If he is alert and wise and particular about every service rendered him, as most people are, and becoming more and more so to-day, he demands it. If he as an alert exacting man has a right to demand it, then every patient has a right to such service, because his right is not founded on the fact that he is wealthy or has social position. The only safe basis on which any right to that kind can be placed is the fact that he is a human being, that he is a creature of God, that his life is his deepest and most fundamental gift. If any one of us has not a right to life we have no rights; and if we have a right to life we have a right to well-being of life, which is health, and of service to bring health back when lost. Out of that fundamental thought comes this right to that exact service fulfilled in the record. More than that, the medical and nursing professions and the managerial part of the hospital owe to the profession itself, owe to the great public which may become a patient at any time, a scientific statement upon which medicine may grow. Medical knowledge, to the extent of seventy per cent. of its mass, has grown out of the scientific records kept by leading men in the profession in Europe and America. Most of the articles written in the numerous medical journals are the reports of men who have kept careful, scientific records. What right has any group of men, anywhere to-day in civilized countries, to refuse to keep records? These are the repositories of scientific data out of which medicine may grow for the benefit of coming generations. It is inescapable. Medical men may say, what have we to do with it? We are busy practitioners. We have to take care of the patients. The next generation can take care of itself. Such an attitude is wrong, wholly unprofessional. It is the busy man, the clinical man, who makes the

records. The laboratory men are at work in the schools and hospitals. They will help. They may discover, they have discovered, many things, but the real growth of medicine as an art comes out of the clinical profession. It is the articles contributed by the clinical men to medical journals which have done most for the profession. When the text books come out the material is five or ten years behind. The knowledge from the laboratory workers reaches the medical profession through a process of slow trickling, but the clinical man who has been a keen observer, and who keeps careful records through a series of cases, comes out with an article which reaches the medical profession of the whole world in a short time. Because, be it said to the credit of the medical profession, they are the keenest readers of their own journals of any profession I know of.

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- 5th. Basins are boiled for ten minutes after each operation, dried, placed in heavy covers and sterilized in autoclave for half an hour before operation.
- 6th. Gloves are washed and boiled after each operation, dried, mended, wrapped in two covers and sterilized in autoclave.
- 7th. Scrubbing of hands. Nurses scrub their hands carefully for ten minutes, first using nail file and brush, then sterile gauze for the last part, as a rule using alcohol sixty

*Introduction to discussion at the monthly meeting of the Medical Staff, on December 9th, 1920.

per cent. or Harrington's solution as a disinfectant. Nurses are taught not to touch outer surface of gloves with bare hands when putting them on. The nurse is instructed how to keep her hands sterile during an operation by handling anything (that might be infected) with forceps.

OUTLINE OF TRAINING FOR THE NURSE IN THE OPERATING ROOM.

1st. Instruction in preparation and handling of sterile supplies and equipment.

2nd. Preparation and care of patient during the administration of anesthetic.

3rd. Later allowed to take minor cases such as tonsils, currtage, cystoscopy, varicose veins, varicocele, and later herniotomy, appendectomy, if she is considered capable of taking major operations, if not, she is allowed to scrub up with another nurse and take sponges under supervision of graduate nurse.

Visitors to O.R. are gowned and wear a cap.

Doctors scrub under running water and place previous used soap in Lysol solution.

In most large hospitals there are internes who take instruments, and the nurse is only required to take sponges and sutures. In many major cases a graduate nurse is overtaxed when she is asked to take instruments, sponges and sutures, especially is this true in an open hospital.

Our policy is to give selective training as far as possible and give O.R. training in the intermediate year.

We have ordered special towel clips.

I would suggest that we have separate wash-up room and dressing-room for the surgeons.

We at present have one of the graduate nurses scrub up for selected major operations.

We feel that our surgeons could do no better than adopt the technique and follow the ritual laid down by Dr. Moynihan in *The British Journal of Surgery*, a short outline of which I shall give you.

One of our graduate nurses, who has recently had post-

graduate work at the University of Minnesota Hospital, states that they always have an interne scrubbed to take instruments and the nurses only attend sutures and sponges. The pupils scrub up and they do not always have a graduate nurse scrubbed up.

Dr. L. S. Mackid, in discussing the subject, spoke as follows:—

I am glad to hear Dr. Fisher state that he is going to introduce selective training for nurses. From the operation-room point, I think this is the only method to be adopted. The introduction of graduate nurses does not mean always efficiency. Just because she is a graduate nurse does not show that she is a surgical nurse. The mere holding of a diploma is no guarantee that she is the one to fill the bill. She has to be tried out first to prove her ability. But from the nurses in the training school you see those who have the inclination and the real desire to become surgical nurses and who show by their ability that they are adapted to that kind of nursing, then give that girl every opportunity to develop along that line. She is a safeguard on your operating room technique because it is her alma mater of nursing and she is loyal to her school. But the nurse who is not interested in O.R. work is a real menace to your room. She doesn't want to know that work because she doesn't like it, but her curriculum says so much time in O.R., so to fill the curriculum requirements you endanger your O.R. technique by harboring a danger. The development by selective training is going to show that a nurse from your school turned out as a surgical nurse has had special advantages offered her because she was inclined mostly that way, so that she can be more dependable in the operating room than the average graduate nurse.

For the general technique of the O.R., I would say this: Team work is absolutely essential from the supervisor down to the duty nurse, doctor and assistant. The nurse supervisor is responsible for everything in the room. The scrub nurse for the instruments, sutures and draping. The assistant scrub nurse for gauze. The duty nurse should keep supplies up and a clear deck around the sterilized area. The doctor for the operative end. No one is more responsible than the other.

Each one is responsible, but I would say to the doctor, as the patient holds you responsible, trust no one, keep your eyes on everything.

As the doctor holds the head nurse responsible, say to her, "Trust no one, keep your eyes open," and to the scrub nurse say the same thing, and the leaks in your operating room technique will always be looked for and corked up when found.

Sir Berkeley Moynihan, in discussing the ritual of a surgical operation, states: This commences before, sometimes long before, the incision is made, and may continue for a long period after the wound is healed. In the transition of a patient from ill health to sound health the operation itself is only one—though it may be the most important—of all the factors concerned in this fortunate event. When conducting our experiments in bacteriology we must recognize that micro-organisms capable of causing the direst disaster may possibly be everywhere—in the air, on the hands, instruments, catgut, etc., which may be introduced in the wound or upon the surface of the patient's body. The possibility of the patient's own tissues furnishing aseptic organisms is so remote that we will it out of account entirely. It is an excuse to condone rather than a reason to explain the occurrence of infection.

Surgery should be a merciful art. The cleaner and gentler the act of operation, the less the patient suffers, the smoother and quicker his convalescence, the more exquisite his healed wound, and the happier his memory of the whole incident, to him probably one of the most important in his life.

Every visitor takes part in the operation—he is gowned and masked and capped, but dirty boots, soiled trouser legs conveying mud and dust from the streets are often unnoticed. Large canvas overalls for the boots and lower part of the leg, tying just below the knee as a sort of legging, will afford ample and secure covering to this possible source of infection.

The surgeon and his assistants (the fewer the better) should change all their external garments before operation. The trousers and coats we all wear are very dirty, though they do not show the dirt. White, sterilized trousers, clean white shoes, sterile coat, cap and mask are all necessary.

The method of preparation of the hands and arms is im-

portant. It is still a common thing to see hands washed in a basin of still water. The moment the hands are soaped and rinsed the water is polluted and the dirt washed off the skin. The best of all plans is to wash under running sterile water. Almost all commercial soaps are sterile. The outer surface may be polluted, but when this is washed away the exposed fresh surface is sterile. Two methods of using soap which are simple and satisfactory: (1) To use a tablet of any household soap which has been lying in a solution of acrosyl for half an hour; or to sterilize some soft green soap in a flat dish in an autoclave, and to rub off time after time with a sterile gauze swab enough of the soap to form a good lather. After washing for not less than fifteen minutes the hands should be gently rubbed with gauze wet in spirit and beniodine solution or in the solution of acrosyl. Rough, chapped hands coarsened by antiseptics, are cleaned with great difficulty, smooth hands, well cared for, are sterile and smooth. A surgeon's hands should always be carefully tended, the nails should be clean, short and smooth and the skin like satin. Once a week a visit to a manicurist is desirable. Gloves should be worn without exception. A glove remains sterile if put on the hand without its outer side being touched with anything except the glove of the other hand or a piece of sterile gauze. With practice it is rare to puncture a glove except in bone operations, and for this it is often an advantage to wear thin cotton gloves over the rubber. If a puncture does occur, a finger stall may be put on or the glove changed in a few seconds. How often are gloves put on without their outer surface being touched or stroked by a bare hand? How often are they considered rather a protection for the surgeon instead of the patient? I have seen gloves put on carefully and the gloved hand then used to palpate the abdomen, and the gloved hand probably smeared with iodine.

The advantage of the dry glove is that it is more comfortable to wear with a long list of operations, and the hand being covered by a dry sterile powder is kept from moisture.

Gloves should be kept on the hands until the dressing of the wound is complete and until the coat and sleeves are removed. If gloves are properly sterilized and properly put on, the covered finger may be used to explore the knee joint or

anywhere else with impunity. Either a long-sleeved gown should be worn, or sleeves which fit firmly around the wrist, there to be covered by the top of the glove.

Preparation of the skin.—It is necessary to prepare the skin for a wide area around the wound. The efficacy of iodine as a skin disinfectant is far less than required and is a powerful irritant. To be effective it must be applied on a dry skin, which often means a dirty skin.

I have very rarely seen a wound healed with all those attributes which are necessary before one is entitled to say that it is "perfect" when iodine alone has been applied. By far the best method of preparing the skin is carried out in three steps: (1) Abundant washing with soap and water, preferably ether soap; (2) gentle friction with beniodide and mercury and spirit solution, 1-500; (3) drying; followed by the application for two or three minutes of Harrington's solution. When the towels are fixed round the operation area a free application of Harrington's solution is made, and throughout all operations the skin is covered with towels so that no friction of the hands against it is possible. The towels which are round the area as closely as possible are fixed to the skin by clips. It is essential to avoid contact with the skin of a patient as much as possible. The hand should not touch the skin at all, viscera should not be allowed to lie upon it, and the rubbing of instruments against it must be avoided. As soon as the incision is made, cloths of several thickness of gauze or towelling should be fixed to the skin edges.

We recommend to all surgeons the perusal of this article, which was found in *The British Journal of Surgery*, July, 1920.

THE TUBERCULOSIS SITUATION IN THE CITY OF CALGARY

THE following are the recommendations as made by Dr. A. Fisher, Superintendent of Calgary City Hospitals, and Dr. C. S. Mahood, City Medical Health Officer, in reference to the tuberculosis situation within the city of Calgary:

1. That the tuberculosis situation should be handled, as far as possible, by the Provincial Health Department.

2. That the tuberculosis sanatorium at Bowness, near Calgary, which has recently been erected by the Dominion Government and the Government of the Province of Alberta, should not be confined to the care of incipient cases only, as in our opinion tuberculosis is not very often diagnosed in the incipient stage, and in the opinion of leading sanatoria superintendents there is no contra-indication to caring for incipient and advanced cases in the same sanatorium.

3. That provision for a central tuberculosis clinic should be made at the Calgary General Hospital, where special wards should be set apart for this purpose. The General Hospital has every facility for carrying on this work, which should be confined to observation and diagnosis.

In the opinion of the best authorities the General Hospital is the proper place to carry on this work. When we accept patients suffering from typhoid fever, there is no reason why we should be afraid of tuberculosis.

4. That the Mount View Hospital, which at present is caring for tuberculosis, might be reserved for a few very advanced cases, but it is not designed for a diagnostic clinic as well.

THREE HIGHLY-RECOMMENDED NURSES GO TO BELLEVILLE

MISS MARGARET TAIT, former Superintendent of the Spadina Military Hospital, Toronto, is the new Superintendent of the Belleville General Hospital. Miss Fell, of Toronto, who has been engaged as Assistant Superintendent, has had overseas experience. Miss Elizabeth Rodgers, who was Dietitian and Housekeeper of Grace Hospital, Toronto, until she went overseas in 1916, has been secured as Dietitian and Housekeeper for the Belleville Hospital. She was also instructing the nurses in training in dietetics. The three new nurses come very highly recommended to the Women's Christian Association, which operates the hospital.

Selected Article

THE SMALL HOSPITAL OR SANATORIUM

S. W. STAADS, M.D., SIOUX CITY, IOWA.

THE Editor's request for articles on the subject of hospitals and similar institutions ought to bring forth a goodly number of responses, because the subject is timely and, by a lively discussion, we all can learn something. Since my ideal had long been a small institution where I could have my operative cases cared for as I would wish to be treated were I the patient, I started our Hillside Sanitarium, in June, 1915.

A large frame building was bought, thoroughly remodeled and fully equipped with operating room, baths and all necessary electrical apparatus to enable us to give our operative cases those great advantages, during convalescence, that a well equipped sanitarium can offer. I engaged a suitable nurse as superintendent and started the Hillside Sanitarium Training School with two pupil nurses. Soon, I had all beds occupied. It was hard work at first to teach both superintendent and nurses what they should know about sanitarium treatments and, at the same time, take care of my patients and supervise the entire household. But since I always have enjoyed hard work along the lines of my profession, I did not mind the work, strenuous as it often was, for the splendid results obtained provided a pleasing compensation for my efforts. Soon, more pupil nurses were accepted and my professional friends assisted me splendidly in lecturing to the class. Still, I could not accept patients from other physicians, as the available room was just sufficient to accommodate my own cases.

After two years, we had grown to such degree that we needed more room and, since we had sufficient ground, we proceeded to erect a fireproof building which, in addition to the first one, gives us room for thirty-eight patients. As a rule, we have all

beds occupied. If labor and material prices were not so excessive, we could now start a large addition to our new building. As it is, that must be postponed.

OPERATING BY ARTIFICIAL LIGHT.

There are a few things that experience has taught us, and which I should like to mention in the hope that it may be of use to other physicians. Our operating room is very plain, but amply large enough for the purpose. It has plenty of light and the so-called "X-ray Light" makes night operating a pleasure. Night operations are done with all the window shades pulled down, even over the skylight, so that all the illuminating rays concentrate on the field of the operation. Electricity furnishes our light and drives our motors, but, in case the electric current should fail us, we have a gas jet in the operating room for the attachment of a portable mantle lamp. This, I believe, is an important provision in case of emergencies.

THE STERILIZER.

Our sterilizing is done in the hospital sterilizer made by the Northwestern Iron and Steel Works at Eau Claire, Wis., gas being used for generating steam, as our small plant furnishes only low-pressure steam for the vapor-heating of our buildings. In connection with this, I wish to say that all sterilizing ought to be done with a control tablet as manufactured by A. W. Diack, Detroit, Mich., for it insures perfect control of efficient sterilizing. A small room next to our sterilizing room is intended for the operators and contains also the Nitrous-Oxide apparatus. This form of anesthesia is my absolute choice of all and we are very fortunate in having a specialist in this line, in our city, who is a master in his art. The greater expense is but a small item when the greater comfort of our operative patients is considered.

MANY CONVENIENCES.

Our halls and stairways are covered with heavy battleship linoleum which is extremely durable and absolutely deadens all

sound. All base coves in our fireproof building are rounded at the floor and corners to prevent dust from gathering there. In rooms for the operative cases, we have ceiling fans. These add so much to the comfort of the patient, in the summer, that I should advise their installation in all institutions for the sick. Patients who are up and around can find shady porches, but not so the bed-patients. Of course every room has its call bell, but, in addition, there is a socket for attaching electrical apparatus such as vibrator, electric heating pads, high-frequency apparatus, light-treatments and others of the kind. I have found all these things to add greatly to the comfort of the patient and to assist wonderfully in the speedy recovery after operations. But we find this little equipment of great value also for non-operative bed patients, for we are thus assisted in giving many other forms of treatment. Let me say, by the way, that three-foot beds are the best and that high-grade casters are an economy.

I advise that all hospitals and sanitariums have one so-called strong room where patients who are at least temporarily mentally aberrated can be placed for safety, and, sometimes, for extensive treatment, for which a sanitarium is wonderfully equipped. The strong room, of course, has everything removed that might endanger the patient himself or others, and all the windows and doors must be heavily guarded with strong iron grills which can be placed in windows and doors very nicely from the inside so that no patient, no matter how strong he is, could possibly pull them off. When the room is not used for a mental case, the gratings can easily be removed and no vestige is left of the former strong room.

CARE OF CHRONIC CASES.

Our Sanitarium proper takes care of a large number of chronic cases and the results obtained by the combined treatments are often marvelous. While my specialty is surgery and my therapeutic classification that of a Homeopath, still, I have found, in my twenty-six years of experience, so many other things that will aid in the cure of the sick, that I feel it my solemn duty to employ them all, regardless of pathy or ism.

With the thought that others might wish that I briefly mention some of them, I should like to say to any doctor who contemplates building his own institution: Learn all you can about nature cure and drugless forms of treatment and employ them and you will greatly increase your usefulness to your patients. The electric-light bath followed by tub-shampoo and cooling needle-spray and then by full body massage will do wonders in starting the patient's elimination. Have your nurses, male and female, learn all of these things and the proper application of static electricity, the sinusoidal currents (my experience shows that the money placed in the Universal mode, made by McIntosh Battery & Optical Co., Chicago, is well invested), light therapy (I prefer the Sterling Lamp of Sterling Therapeutic Lamp Co., 546 Garfield Avenue, Chicago), high frequency currents (buy from Victor Electric Corporation, Chicago, one of their larger machines), electric sitz baths, vibrating chair, etc. You cannot do all the work, but your nurses will, thus giving you time for your more important work. It is my opinion that only the experienced physician should apply galvanic currents to the sick, for only he can properly handle this scientific variety of the electric modalities. Think what you please of the Oxyoline apparatus made by the Ozone Company of America, Milwaukee; but I use two of them with great satisfaction and would not be without them. Doctor Roemer's Tension Table (Physician's Supply Co., Waukegan, Ill.) is undoubtedly a fine addition to our armamentarium and soon will find favor with any physician who uses it. The Burdick Cabinet Co., 100 Atlantic Avenue, Milton, Wis., makes very fine cabinets and lamps. Of course, the Frank S. Betz Co., of Hammond, Ind., also supplies all of these things.

KITCHEN AND DINING ROOM.

The kitchen of a well arranged institution, even if it is small, is of paramount importance, and a large salary paid to a good cook and her assistants always is a good investment. That all food should be the best that money can buy, goes without saying. All labor-saving devices, such as bread cutters, butter cutters, electric dishwashers and many others, soon pay for themselves.

In this connection, I wish to recommend the new compartment plates, especially for bed-patients. They look well, wear well, save dish-washing labor and, since they are of heavy china, keep themselves and the foods warm for a long time.

The dining room is very important and, personally, I think that tables for six are the most practical. We have a nurse preside at each table, and it is her duty to see to it that the patients get the prescribed food; also, to keep up a pleasant conversation during meal time. [This means, of course, to steer clear of the ever-present topic, viz., illness and methods of treatment. It is so injurious to the patients that, often, we have wished it were possible to muzzle them.—Ed.] Our nurses and out-of-bed patients eat their meals at noon and evening at the same time in the dining room. This may be criticized, but it is my choice for our condition.

LAUNDRY, CLEANING, LIGHTING.

The question is still open, whether the institution saves money by having its own laundry or by engaging a downtown laundry. Personally, I am in favor of the former practice. A good-sized rotary washing machine, extractor, hot mangle, all driven by electricity, and several electric irons are to be recommended.

A vacuum system built into the house is, of course, ideal, but a good substitute is afforded by an electric vacuum cleaner or sweeper. The initial cost is moderate and the result fine.

Where electric lights are used, it pays to have the "Dim-a-Light" attached to every one; it is a comfort to the patient and makes for effective economy.

THE TRAINING SCHOOL.

The training school, of course, endeavors to fulfil the demands of the State Board, and, as previously stated, colleagues assist us splendidly in our lecture work. We consider it a great advantage to use the Chase Doll for the teaching of the probationers, the skeleton, Frohse Charts, Anatomical models, Betz's large new Smith's Manikin, microscopic slides, and so

forth, for the general studies of the nurses. One thing we always impress upon their minds, and which we think has been of great advantage is: Keep smiling, work hard and treat your patient with the kindness and consideration that you would wish, were you the patient. For more than twenty years I have trained nurses and lectured to them, and I am firmly convinced that often the best high school graduate makes a poorer nurse than a grade school graduate with love for her work. In a great measure, nurses are born, not made.

Slamming of doors must be overcome by education of the nurses and by having on each door one of the smaller Yale or Corbin door checks, which close the door noiselessly, and you are spared the often useless task of educating nurses and patients. It pays to overcome these useless and (especially of nights) nerve-racking noises.

SOME OTHER HELPS.

Auto-Hemic Therapy (Dr. L. D. Rogers, 546 Surf Street, Chicago) and Auto-Therapy (Dr. Chas. Duncan, 2826 Broadway, New York) are my staunch friends without which I would not care to practise. The same applies to the Hensel Nutritive-Salt Therapy (Hillside Health Food Co., Sioux City, Iowa), one of the really good things we got from Germany and a stand-by in chronic diseases. Radium-Therapy has seldom disappointed me and, while expensive, has proven worth all the money paid for it.

But, above all therapeutic measures, I prize Homeopathy. Men who claim to have tried Homeopathy properly and then forsaken this art must be so small in number and so diminutive in intellect that it would take a strong magnifying lens to see them.

We find that it is a good investment to give the out-of-bed patients the advantages of our parlors, where they have their visits, their games, a good library, magazines and daily papers, Victrola music, electric fountain, moving pictures (we use the De Vry Portable Projector and lease films weekly, both from Atlas Educational Film Co., 63 E. Adams Street, Chicago), canary birds, gold fishes and the like. Placards on the wall

say: Have a good time, but do not discuss politics, religion, or your troubles. Tell the latter to your doctor or nurse only.

Last, but not least, I recommend that you carry insurance against damages from fire, tornado, employers' liability, malpractice, etc., and that you lessen your work by having an efficient private secretary keep all your books and to take care of your correspondence, using the dictaphone.

It is true I have written a much longer article than I had intended, but I thought that while writing it would be best to give full information, also as to the sources of supplies, than to have loss of time by inviting avoidable correspondence.—
Journal of Clinical Medicine.

ALCOHOL FOR HOSPITALS

WE are glad to note that the Canadian Department of Inland Revenue recently issued orders with regard to the sale of alcohol to hospitals. As our readers are well aware, the hospitals throughout the Province of Ontario particularly, have been up against it of recent years as to the procuring of alcohol for medicinal purposes, and THE HOSPITAL WORLD takes a small share of the credit for the recent order issued at Ottawa. The order is as follows:

“Spirits may be removed (from distilleries) for use in public hospitals upon payment of the excise duty and excise tax collectable thereon for the manufacture of linaments, tinctures, or similar medicinal preparations, or for bathing patients, upon the receipt by the distiller of an affidavit made in each case by the superintendent of the hospital, to the effect that said spirits will be employed solely and entirely for the purposes indicated, and that no portion thereof will be diverted to any other use.”

Items

GRACE HOSPITAL ASKS CITY TO HELP WIPE OFF DEFICIT

A LETTER from E. R. Wood, chairman of the Board of Governors of Grace Hospital, enclosing a statement in support of an application for a grant towards the deficit of the hospital was read to the Board of Control, Toronto, on December 8th.

The matter was referred to the M.O.H. and the Finance Commissioner for report.

The letter and statement, which show the increase in prices since last year, follow:

"On behalf of the Board of Governors of Grace Hospital, I beg to make application for a grant towards the deficit which the enclosed statement shows in the maintenance account of the hospital. A reference to the statement will show that the deficit in our operating accounts for the year ended September 30th, 1920, amounts to \$19,607.66. In common with other hospitals, the rates for private and semi-private patients, and other charges in connection with the hospital, have been increased during the year. As a result, the total income of the institution for the year shows a considerable gain over the preceding twelve months, but not sufficient to keep pace with the greatly increased cost of operation. In the circumstances, therefore, it is the sincere hope of our board that this application for a grant of \$19,607.66 will meet with your favorable consideration.

MONEY FOR HOSPITAL

THE Stamford Township Council will submit a by-law to raise \$10,000 by debentures, to be given as a grant to the Niagara Falls Hospital. There is no hospital in the township and large additions are being made to the local hospital to which the grant will be applied.

GREY NUNS WANT HOSPITAL

It is rumored that the Grey Nuns are contemplating the purchase of the Ontario Hospital at Penetanguishene, with a view to using it as a convent. The Grey Nuns, with their mother house in Montreal, were large stockholders in the Toronto Railway Company. If the building is sold by the Ontario Government, the purchase price thus may be paid by money provided by the citizens of Toronto.

Hon. F. C. Biggs, Minister of Public Works, denies that there have been any negotiations for the sale of the Penetanguishene Hospital to the Grey Nuns. He admitted patients were being transmitted to other hospitals.

Hon. H. C. Nixon, Provincial Secretary, says that the patients who are now inmates of the hospital are not being transferred to another hospital.

ORANGE ORPHANS' HOME

BUILDING operations for the new home to be built at Stop 51, Yonge Street, by the New Loyal True Blue and Orange Orphanage will begin next spring. Up to November 30th the Orphanage had \$47,036.60 in the bank and \$35,000 in Victory Bonds.

The land was purchased for \$15,500, which makes a total of \$97,536.60 collected, and leaving \$82,036.60 for the building. A promise of \$21,000 more will mean that \$103,036.60 will be available when building operations begin.

ISOLATION HOSPITAL BURNS

THE Infectious Diseases Hospital on Signal Hill, St. John's, Newfoundland, was destroyed by fire on December 18th. A nursing staff and six patients were in the building when the alarm was given, but all escaped without injury.

NURSE NOT NEGLIGENT

MAGISTRATE WATT, on December 8th, honorably discharged Miss Catherine McEacheran, the nurse at the Homewood Sanitarium, who was charged with negligence in the death by scalding of a patient.

In giving judgment, the magistrate declared: "I cannot find that Miss McEacheran was negligent in any way. Her instructions were to stay by her patient unless in an emergency. The emergency clearly arose when a patient called out for help, and Miss McEacheran, true to her instructions, and her obvious duty, went to the assistance of the patient.

"Unfortunately, with the perversity with which things sometimes happen, the mechanism controlling the temperature of the water in the bath failed, the water became too hot, and Mrs. Lepfosky died.

"I cannot find that she was scalded to death, for she made no outcry. That, however, is outside of my province in the case, but for her death I cannot find that Miss McEacheran was in any way to blame, and she will be honorably discharged."

ASKS FOR GRANT

THE Board of Control, Toronto, on December 8th, heard a deputation, headed by S. Johnston, K.C., asking that the city grant \$90,000 towards the maintenance of the Hospital for Sick Children. Mr. Johnston declared that the costs of maintenance have risen from \$171,000 in 1916, to \$359,000 in 1920, and that there is a bank overdraft of \$145,000 now, for which the directors are personally responsible.

A NEW motor ambulance has been donated to the Kitchener and Waterloo Hospital by the Graduate Nurses' Association. It is one of the most modern of its kind in the Province.

NOTICE OF EXTENSION OF PARTNERSHIP

TEN years ago, realizing the increasing demand for well designed medical and institutional buildings, I decided to confine my practice, already tending in that direction, to that branch of architecture exclusively. The consequent increase in volume of work and in the extended area of territory covered made it advisable in 1912, in order to care for my Canadian practice, to form a partnership with Mr. Frederick C. Lee, of Toronto, and an office was opened in that city under the firm name of Stevens & Lee. The success of that office and the additional architectural service I have been able to render my clients from this Canadian partnership has caused my decision to make Mr. Lee's services available to my clients on this side of the border and, in the future, to carry on my practice, in United States as well as in Canada, under the firm name of Stevens & Lee. While Mr. Lee, as well as myself, will be available at all times for consultations both in the States and in Canada, Mr. Lee will as heretofore be located at the Canadian office.

EDWARD F. STEVENS.

Boston, January 1, 1921.

FREEPORT SANITARIUM OPENS

THE Freeport Sanitarium, at Kitchener, for tubercular cases, opened on December 13th with a registration of eight patients. Three of the patients have been transferred from Gravenhurst and five are residents of the county. Dr. R. Proctor is physician-in-chief. He held that position when the institution was under the direction of the Military Hospitals Commission.

INSANE ASYLUM BURNS

ACCORDING to the lay press, the Insane Asylum at St. Peters, C.B., was destroyed by fire on December 22nd. There were about thirty patients in the building at the time, but no casualties.

AMALGAMATION OF THE MONTREAL GENERAL AND WESTERN HOSPITALS

AFTER negotiations, lasting over a period of one year, between the Boards of Management of the Western Hospital and the Montreal General Hospital, of Montreal, it has been decided to amalgamate these two hospitals, and at the coming session of the Quebec Legislature, application is being made for a new charter, under which this amalgamation may be consummated.

It is the intention of the combined Boards to build on the present grounds of the Western Hospital a Private Patients' Pavilion of from 250 to 300 rooms, which will be open to any recognized physician or surgeon of good standing in the community, who is willing to meet the minimum standard requirements of the American College of Surgeons; also emergency wards for male and female patients, and a large out-patient department to take care of that end of the city.

The present Montreal General Hospital will be completed and occupied only by public patients. It is expected that this amalgamation will enable the Governing Boards to administer the hospitals more efficiently, cut down expenses, and offer to the sick of Montreal, rich and poor alike, better service and, in addition, offer better teaching facilities for the University of McGill.

SUGGESTIONS AS TO REMOVAL OF ONTARIO HOSPITAL, HAMILTON

ALD. THOMAS MCQUESTEN, at the meeting on December 14th, of the Hamilton City Council, gave notice of motion that he would urge the Council at an early date to petition the Ontario Government to effect the gradual removal of the Ontario Hospital, located on the Mountain at the head of Queen Street. The Alderman contended that the institution should be removed to a site more remote from the city.

CLAUSE IN CITY'S BILL FOR THE HOSPITAL BY-LAW

THE City Council of Kitchener, at its inaugural meeting, was requested by a delegation representing the Kitchener & Waterloo Hospital Board, to include a clause in the proposed private bill to be introduced at this session of the Legislature to validate the by-law to raise \$37,000 for the hospital, which was defeated on account of an insufficient vote. Hon. H. C. Nixon, Provincial Secretary, has recommended that this action be adopted, and has pledged his support.

THE NEW WHITBY MEMORIAL HOSPITAL

WORKMEN commenced last month to clear the site for the new Whitby Memorial Hospital which is to be erected here. The hospital will be situated on the Perry Castle Block.

OBJECT TO PROPOSED REGULATIONS FOR NURSES

DOCTORS and nurses from Western Ontario waited on Provincial Secretary Nixon on December 2nd, and asked that the proposed regulations for the regulation of nurses be amended. There was discrimination against the smaller outside hospitals. The new "order" was being put through by big centres.

Judge Fisher, of Orangeville, told the Minister that, if the regulations were carried out in their present form, they would shut down the hospital at Orangeville. Dr. Groves, of Fergus, spoke in a similar strain and stated that the smaller town hospitals simply could not afford to live up to the regulations in their present form.

The Minister promised to give the matter his consideration.

Book Reviews

An Introduction to Bacteriology for Nurses. By HARRY W. CAREY, M.D., Assistant Bacteriologist, Bender Hygienic Laboratory, Albany, N.Y. Second edition, revised. Philadelphia: The F. A. Davis Company, publishers. English depot: Stanley Phillips, London. 1920. Price \$1.25 net.

This little volume presents most of the salient points in elementary bacteriology in a simple, non-technical form suitable to the needs of the average nurse. It seems to the reviewer, however, that, for nurses, more attention should be paid to such subjects as asepsis, antisepsis, sterilization (including disinfection), methods of contagion, routes of infection, bacteriology of food, milk and water, and less to some of the rarer forms of bacteria. The classification of bacteria into (1) pyogenic, (2) intestinal, (3) those causing acute infections, (4) those causing chronic infections, is hardly satisfactory since practically all those in group (1) could be reasonably included in group (3).

Practical Physics for Nurses. By MINNIE GOODNOW, R.N., formerly Directress of Nurses, Milwaukee County Hospital; formerly Superintendent of the Woman's Hospital, Denver; and of the Bronson Hospital, Kalamazoo. With 100 illustrations. W. B. Saunders Company. 1919. Philadelphia and London. Cloth, \$1.75 net. The J. F. Hartz Co., Ltd., Toronto, Canadian agents.

It is extremely difficult to treat such a vast subject as physical science in a concise and practical way and at the same time avoid obscurity of meaning. The subject is well dealt with in this little book. It contains all the essentials of the science that a nurse should know, and by practically applying each principle to some phase of nursing practice, assists memory in retaining the facts. It is very readable and practical and should be of great benefit to the nursing profession.

The Ophthalmic Nurse. By G. GRIFFITH LEWIS, M.D., Oculist to Grouse-Irving Hospital, Syracuse, N.Y. 12mo of 176 pages, with 102 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$1.50 net. Canadian agents: The J. F. Hartz Co., Ltd., Toronto.

This little book should be a valuable addition to the Nurses' and Training School libraries. The anatomy, physiology and hygiene of the eye are briefly discussed in the early chapters. Then follow four chapters devoted to ophthalmic nursing. The last two chapters should prove very useful from a reference point of view, as they constitute a veritable encyclopedia of ophthalmic drugs, instruments, diseases and operations.

Outline of Internal Medicine, for the use of nurses and junior medical students. By CLIFFORD BAILEY FARR, A.M., M.D., Professor of Gastro-Enterology, Graduate School of Medicine, and Associate in Medicine, Medical Department, University of Pennsylvania. Third and revised edition, illustrated with seventy engravings and six plates. Lea & Febiger, publishers, Philadelphia and New York. 1920.

This book most admirably answers the purpose for which it was written. For the nurse in training or for the graduate nurse, it will be found to be a most useful book of reference, and to those who lecture to nurses' training schools it will be found useful for the suggestions that are in it. The difficulty in writing such a book must always lie in deciding what should be omitted and what should be included. The author has used good judgment in this case, and there is very little fault to find. It would seem that functional nervous systems have not been sufficiently stressed. For instance, no mention is made of worry as a cause for insomnia or vertigo. In the section on arterial sclerosis the difference between arterial sclerosis secondary to high blood pressure and primary arterial sclerosis is not made sufficiently clear. No mention is made

of the various test meals for testing kidney function, although the phenolsulphonalphthalein test is described. It is doubtful if many authors at present would go so far as this one in recommending cold bath for typhoid. The tendency of the last ten years, certainly in this locality at least, is to use the tepid rather than the cold bath. These are minor defects, and the author is to be congratulated on his satisfactory little volume.

An Epitome of Hydrotherapy, for Physicians, Architects and Nurses. By SIMON BARUCH, M.D., LL.D., Consulting Physician to Knickerbocker and Montefiori Hospitals, Consulting Hydrotherapeutist to Bellevue Hospital, New York City, formerly Professor of Hydrotherapy, College of Physicians and Surgeons, Columbia University. Illustrated. Philadelphia and London. 1920. W. B. Saunders Company. Cloth, \$2.00 net. Canadian agents: The J. F. Hartz Co., Limited, Toronto.

This is a brief description and a practical review of the principles and methods of hydrotherapy. The author is not unknown in medical writings, his text-book on the Principles and Practice of Hydrotherapy, in 1898, which was republished in London, Paris, and Berlin, and other works, speak for the value of this volume. Every part of the question of bathing has been thoroughly gone into, from the simple, every-day use of the bath to all those forms of hydrotherapy which are used in the present day. There is also a full description of the different apparatus used in the application of hydrotherapy and a detailed description of how this agent is used and what results may be accomplished from its use in a very great number of diseased conditions. It is a book that will be read with interest, as it contains much that is not found in any other text-book, and which is of great value to the medical practitioner.

THEIR DEPARTURE DEEPLY REGRETTED

ON December first the medical practitioners of the city met at Belleville Hospital and presented Miss Green, Superintendent, and Miss Morrison, Assistant Superintendent, with club bags on their retirement from the hospital. In an address the doctors expressed their regret at the departure of these ladies, to whom the hospital had owed so much. The Alumnae Association of the hospital, composed of graduate nurses, presented Miss Green with a beautiful pair of opera glasses, and Miss Morrison with a gold wrist watch, and referred to the loss the institution would sustain in their departure. The nurses in training presented the Superintendent with a small desk clock, and Miss Morrison with a silver mesh purse.

DEPARTMENT OF HEALTH DESIRES DECLARATION

THE Federal Department of Health some weeks ago mailed to all physicians, veterinary surgeons, dentists and druggists in Canada, form No. 6, on which to make the declaration as provided under the Act, showing that they are engaged in the sale or distribution of narcotics. Very heavy penalties are provided under the Act for neglecting or refusing to furnish the declaration in question: a fine of not less than \$200.00 and costs, and not more than \$1,000.00 and costs, or to a term of imprisonment of one year, or to both fine and imprisonment, being the penalties specified for non-compliance with the regulations. As a number of physicians, veterinary surgeons, dentists and druggists have not so far sent in the required declaration, the Department has advised the editor that unless this declaration is received within a reasonable period, the law will be enforced and penalties levied upon all delinquents. It should be noted that all physicians who obtain narcotics in any quantity to administer directly to their patients, are con-

sidered to be engaged in the distribution of these drugs: likewise all dentists and veterinary surgeons who obtain supplies of these drugs for use in connection with their practice, are considered to be engaged in the distribution of narcotics, and it is, therefore, necessary for them to make the declaration as required under the Act as amended at the last session of Parliament.

GALT MATERNITY HOSPITAL

At a special meeting of the City Council of Galt, on December 7th, a by-law to go to the electors on January 1st, to raise \$55,000 for an addition to the Maternity Hospital, was given its first and second readings. W. B. Powell has been elected President of the Hospital Trust for this year; W. H. Lutz, Secretary since the formation of the Trust, thirty-two years ago, has been re-elected, and P. J. Wright is Treasurer.

NURSE CAVELL

"One Who Met a Martyr's Fate."

MEMORIAL UNVEILED BY QUEEN ALEXANDRA.

QUEEN ALEXANDRA, the life-long friend of the nursing profession, unveiled at St. Martin's Place, Trafalgar Square, in presence of a large Anglo-Belgian assembly, a statue of Edith Cavell, the nurse who was a victim of German brutality. Very appropriately the statue was draped for the ceremony with British and Belgian flags, presented by Queen Alexandra and the Queen of the Belgians respectively, and these flags, with a memorial flag sent by the Queen of the Belgians, will find a permanent place in the London Hospital, the institution in which Nurse Cavell received her professional training.

Queen Alexandra drove to the Square from Marlborough House, and was received by Viscount Burnham, Chairman of

the Memorial Committee, who made a series of presentations, including that of Mr. J. Hall Richardson, to whose energetic and efficient secretarial work the memorial movement, organized by the *Daily Telegraph*, owed its success in very large measure.

“ A LABOR OF LOVE.”

These preliminaries over, Viscount Burnham invited Her Majesty to unveil the memorial, addressing her as follows:—

“ The Committee of the Cavell Memorial wish me to tender our humble duty to Your Majesty, and to thank you for the great honor that Your Majesty has done us in consenting to unveil the statue which has been executed by Sir George Frampton, to use his own words, as a ‘labor of love.’ The monument has been erected out of a fund subscribed by readers of the *Daily Telegraph*. Subscriptions came from every class of the community, mostly in small sums—and a large number of those who sent us money were men on active service—through collections made on board His Majesty’s ships, and in regimental messes and institutions. The interest was not confined to these islands, and many sent us money from across the Channel in honor of her whom the French describe as the ‘Joan of Arc of England.’ The Westminster City Council, within a week of the opening of the fund, offered this magnificent site, and the First Commissioner of Works, then Lord Harcourt, promptly gave his consent on behalf of the Crown. It was on this ideal site that the Gordon statue stood for a time before it was removed to Khartoum. The original estimates have been largely exceeded, owing to the rise in price of labor and material during the war, and this ceremony has been delayed because Sir George Frampton could not for a long time obtain the splendid block of Carrara marble which he wanted. The monument of grey granite stands forty feet high, and weighs 175 tons. On the four panels are the words, ‘Humanity,’ ‘Sacrifice,’ ‘Devotion,’ and ‘Fortitude.’ On the back is the British Lion trampling on a serpent, symbolical of envy, spite, malice and treachery, and above it are the words ‘Faithful Unto Death.’” The statue of white marble, in itself the emblem of purity, shows Nurse Cavell

standing erect in her nurse's uniform. On the vase is the simple inscription:—

EDITH CAVELL.

BRUSSELS.

Dawn, October 12, 1915.

"May I add that we think we could commemorate in no nobler fashion the heroic memory of this plain nurse from the London Hospital who showed the shining qualities of womanhood and citizenship in her life and by her death, to the lasting glory of her profession and her country. We have also to thank Your Majesty for presenting the Union Jack, which is entwined with the Belgian Flag, presented by Her Majesty the Queen of the Belgians, and brought here by the Belgian delegation from the Ecole Edith Cavell of Brussels. The two flags are draped together over the statue of Nurse Cavell in token of the common admiration and the common sacrifice of our two allied and friendly nations. We cannot here and now be unmindful that His late Majesty King Edward VII was the foremost champion of the European freedom and civilization for which Edith Cavell gave her life. To-day we enshrine her memory."

"COURAGE AND RESIGNATION RARELY EXCELLED."

Queen Alexandra replied in the following terms:—

"I sincerely thank the Mayor and Council of the City of Westminster for the welcome they have given me this morning, and you, Lord Burnham, as Chairman of the Cavell Memorial Committee, for your kind words and touching references to my beloved husband King Edward. It gives me the greatest pleasure to unveil this statue, and to have the opportunity of expressing my admiration and respect for the memory of that good and brave lady Nurse Edith Cavell. I hear with interest from Lord Burnham of the wonderful response which has been made to the appeal issued by the *Daily Telegraph*, and that all classes of the community have so generously subscribed to the monument. This beautiful statue—the work of our distin-

guished sculptor Sir George Frampton—will stand for all time as a memorial of one who met a martyr's fate with calm courage and resignation which has rarely been excelled, and we recall the beautiful words which, when death was very near, Miss Cavell wrote to a friend:—

‘Nothing matters when one comes to the last hour but a clear conscience before God. I wish you to know that I was neither afraid nor unhappy, but quite ready to give my life for England.’

“The countless thousands who will pass this spot in our time and in future generations will think with sorrow of her cruel death, with pride of her splendid fortitude, and with affection of her unselfish and womanly character. The example of Miss Edith Cavell's life will be always before us, and her name will remain honored and revered throughout the Empire. I am particularly glad to welcome the Belgian delegation to-day, and to join with the Queen of the Belgians in presenting our National Flags upon this occasion. The blending of them together is symbolical of the friendship and alliance which exists and, please God, will always exist between our countries. Once more I thank you, with my assurances that it has been a privilege and pleasure to me to perform this ceremony to-day.”

IMPRESSIVE CEREMONY.

The scene at the unveiling ceremony was a remarkable and impressive one. Sightseers thronged the whole neighborhood of the statue. On every side of it, save only where a carriage-way was kept open for Queen Alexandra, there was a sea of faces, all strained earnestly towards the veiled statue, and on the fringes of the great crowd house roofs, windows, and other points of vantage were fully occupied. In the reserved enclosure about the base of the statue were a number of representative people, including Mr. Burdett Coutts, member for the Abbey Division of Westminster; Mrs. Asquith, Mr. Gilbert (new Chairman of the L.C.C.), the Dean of Westminster, the Lord Mayor and Sheriffs of London, the Bishop of London, the Belgian Ambassador, Sir Alfred Mond, and Viscount Knutsford (Chairman of the London Hospital.)

Among those in the immediate neighborhood of the enclosure were nurses from all the London hospitals and from the Ecole Cavell at Brussels. A guard of honor of the Coldstream Guards was posted on one side of the statue. Drummers and buglers occupied a position on the southern side of the plinth, and the band of the Coldstream Guards was in position on the opposite side.

Queen Alexandra, who was accompanied by Princess Victoria and was attended by several members of her suite, including Earl Howes, the Hon. Charlotte Knollys, General Sir Dighton Probyn, V.C., and Colonel Sir Henry Streatfeild, was received with ringing cheers and with a Royal salute.

After the address and reply, the Bishop of London stood on the plinth immediately beneath the figure of Nurse Cavell, and offered a short dedicatory prayer.

THE STATUE UNVEILED.

Queen Alexandra, at the invitation of Viscount Burnham, drew the central rope holding the veiling flags in position. Meanwhile Miss Monk (Matron of the London Hospital) and Miss Smith (Matron-in-Chief of Army Nurses) assisted Her Majesty by pulling on supplementary cords.

When Sir George Frampton's work was fully disclosed to view there was a period of tense silence, broken by the band in the rear, which commenced to play a verse of "Abide with me." The multitude sang to their accompaniment, but it was at best only a feeble performance, and the last words ended in something very like a sob. It was noticed that many of those in the huge assemblage, particularly the women, were moved to tears by the pathos and significance of the occasion. Following the hymn came the sounding of the "Last Post" by the buglers, and then, after an impressive roll of drums, *Reveille* also was sounded, and so ended the notable ceremony. A further Royal salute was given, and the National Anthem was once again played as Queen Alexandra drove back to Marlborough House amid the renewed cheers of the people.

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TRAINING SCHOOL REGULATION AND NURSE REGISTRATION

WE have received a copy of regulations suggested for training schools for nurses and registration of nurses. Graduates of registered training schools resident and practising in Ontario, twenty-one, and of good character, having passed the Board of Examiners (hereinafter referred to) may use the title R. N. Fee \$5.00. Applications for registration will have to be made to the Council of Nurse Education. Examinations will be held twice yearly, of which notice will be given. The council shall appoint two nurses in each district as examiners. The fees go to the Department of the Provincial Secretary; this department will pay the examiners. Former graduates of approved training schools will escape exams. Nurses in training of approved schools will be admitted on passing their own school finals and payment of fee. Registered nurses of other provinces or states need not be examined to get in. Nurses from provinces or states which have no register, graduates of approved schools, if practising one year, are allowed in—within two years after the coming into force of the Act; as may also non-registered nurses graduated from a registered school in a province or state in which registration obtains; if in practice a year, a certificate is given. There is an annual fee of \$1.00.

The Nurse Education Council shall be composed of the inspector of hospitals, three physicians and five teaching nurses.

INSPECTOR OF TRAINING SCHOOLS.

(a) There shall also be appointed an inspector of training schools for nurses, the appointee to be a nurse who may be recommended by, but not a member of, the Council of Nurse Education. This officer shall be appointed by, and be attached to, the Department of the Provincial Secretary, and shall be paid a suitable salary in addition to travelling expenses.

(b) The inspector of training schools, in conjunction with the Council of Nurse Education, shall draw up regulations for

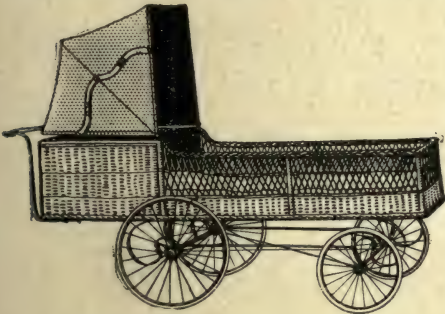
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the conduct of training schools for nurses in the Province, subject to the approval of the Lieutenant-Governor-in-Council, and shall keep a register of such schools as meet the minimum requirements, which register shall at all times be open for inspection by members of the council.

Such registered training schools for nurses shall maintain a standard as to facilities and curriculum not lower than that set forth in the following:—

THE FOLLOWING GENERAL RECOMMENDATIONS ARE MADE.

(a) That at least one year High School or its equivalent be required for standard of admission.

(b) That a probationary term of not less than three months be maintained, and that probationers be admitted if possible in classes at regular intervals.

(c) That a preliminary course of study, of not less than three months' duration be given to each class, such course to include practical demonstrations of general nursing methods.

(d) That at least two weeks of preliminary course be given before allowing pupils to assume any nursing responsibility.

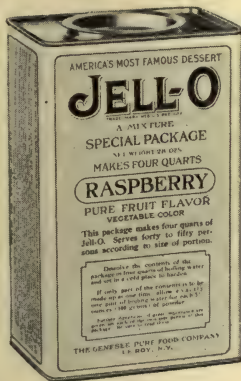
(e) That pupil nurses should not be called upon to give more than sixty-three hours per week to their work, including class hours and exclusive of time off duty. All time lost by illness of pupils should be made up at the end of the course.

(f) That all hospitals which cannot give one of the courses hereinafter outlined in its entirety, should seek affiliation with other hospitals in the subject not covered by the class of patients under treatment.

(g) That a vacation of at least two weeks per year be allowed all pupils.

(h) That all hospitals maintaining training schools of any character, including hospitals for the insane, employ a graduate nurse as superintendent of nurses.

(i) That no hospital should attempt to maintain a training school for nurses if it cannot meet the requirements of the



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minimum course, or arrange affiliation with other hospitals that will provide full equivalents.

(j) That training schools should not be maintained in any hospitals without at least two paid resident instructors being provided for the teaching of nurses, one of whom must be principal of the training school, and the other day assistant. That all hospitals, irrespective of size, have a graduate nurse as night supervisor. This number of qualified graduates should be considered the absolute minimum, irrespective of the size of the school.

(k) The superintendent of nurses must be a registered nurse or be eligible for registration.

These regulations shall not be construed to affect or apply to the gratuitous nursing of the sick by friends or members of the family of the sick person, nor to any person nursing the sick for hire, who does not in any way assume or pretend to be a registered nurse.

The Coming Census

CANADA is preparing to take a census, in 1921, of the dwellers within the nation's borders—a task which was last undertaken in 1911. It is suggested that among the questions to be asked there might be included an inquiry as to the smoking proclivities of the people. Certainly there has been a remarkable increase during the past ten years in the use of tobacco by citizens of the Dominion, with a decided preference for the cigarette as the favored form of smoke.

Dominion Artificial Limbs

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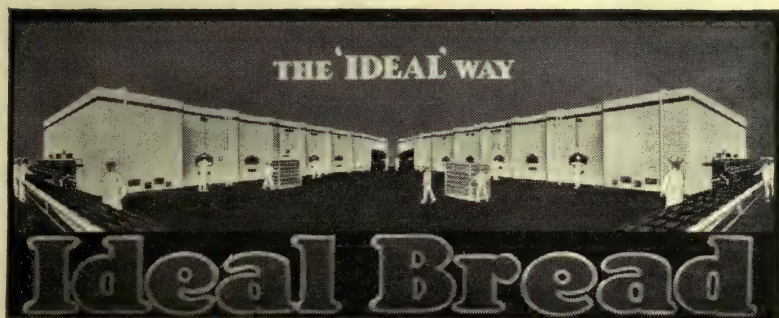
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THE efficiency of the Durham Duplex Razor was put to a severe test on the battle-fields of Europe during the World War. Many a comfortable shave was had by the men in the trenches, under otherwise uncomfortable conditions. It was in evidence in the rest billets and camps. In the hospitals, doctors and nurses found the Durham Duplex Razor indispensable in treating wounds that required the removal of the hair. Shaving was absolutely safe, blades could be quickly replaced when necessary, and sterilization of all parts was readily effected.

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Durham Duplex Razors have been used in hospitals, clinics, etc., for many years, both for professional purposes as well as by the doctors for personal use. They realize that the principle is right, and that it enables them to shave with the sliding, diagonal stroke—down and across the beard—with comfort, speed and perfect safety.

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The Durham Duplex Razor Safety, therefore, admits of that satisfactory diagonal sweeping stroke across the face, which leaves a perfectly smooth surface. The beard yields readily before its movement. It shaves, and does not in the least degree scrape. The keen edges last a long time. The moment its advantages are learned the razor becomes a favorite. The razor we examined and submitted to careful practical trial.

"THE BRITISH MEDICAL JOURNAL"

The Durham Duplex Razor Safety is well guarded so that an accidental cut seems almost impossible, while to many who have been in the habit of shaving themselves for years it will present the advantage that it can be used in the way to which they are accustomed in rounding corners and negotiating wrinkles.



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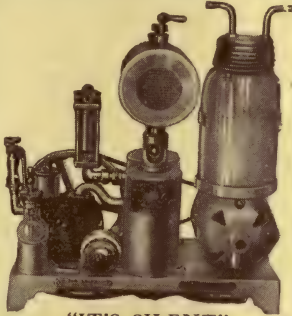
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THE HOSPITAL WORLD

Vol. XIX

Toronto, March, 1921

No. 3

CONTENTS

EDITORIALS

	Page
Sir William Gage	77
How to Make Hospitals Self-Sustaining	80
Trustee Boards	81

ORIGINAL CONTRIBUTION

Provincial Hospital Organization in Canada. By M. T. MacEachern, M.D., C.M.	85
--	----

SOCIETY PROCEEDINGS

	Page
The American Hospital Association.	101

CANADIAN HOSPITALS

Sir Joseph Flavelle and Mr. P. C. Larkin Retire	105
Toronto's New Reception Hospital.	108
Brantford Urged to Build Isolation Hospital at Once	108

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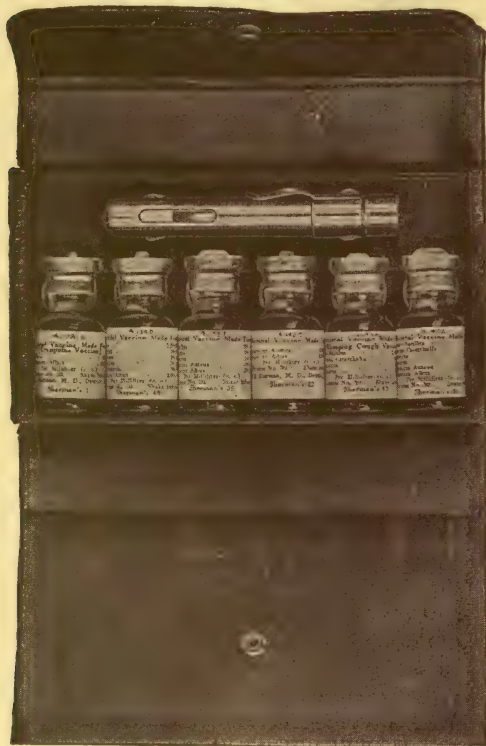
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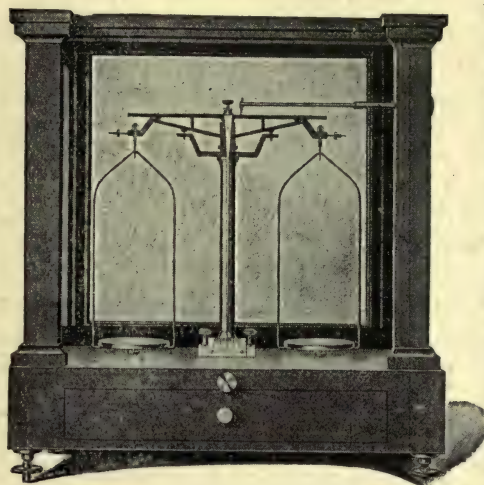
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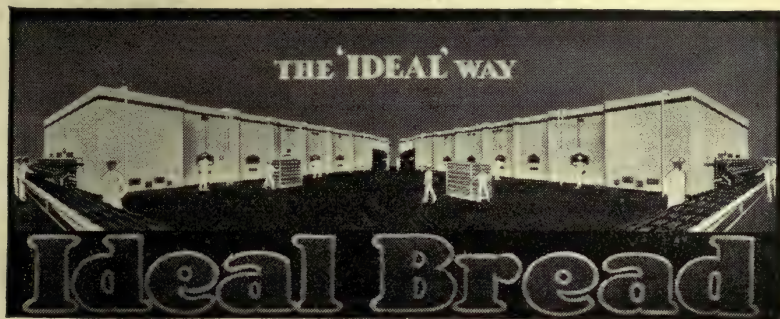
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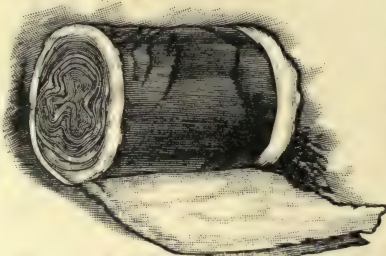
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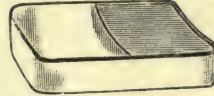
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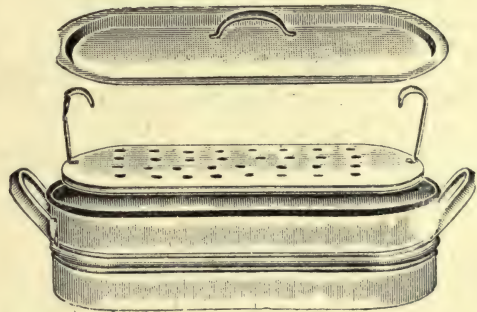
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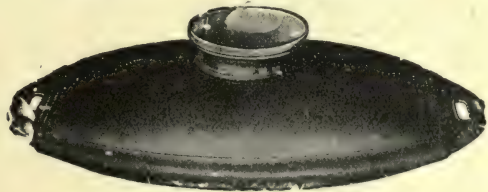
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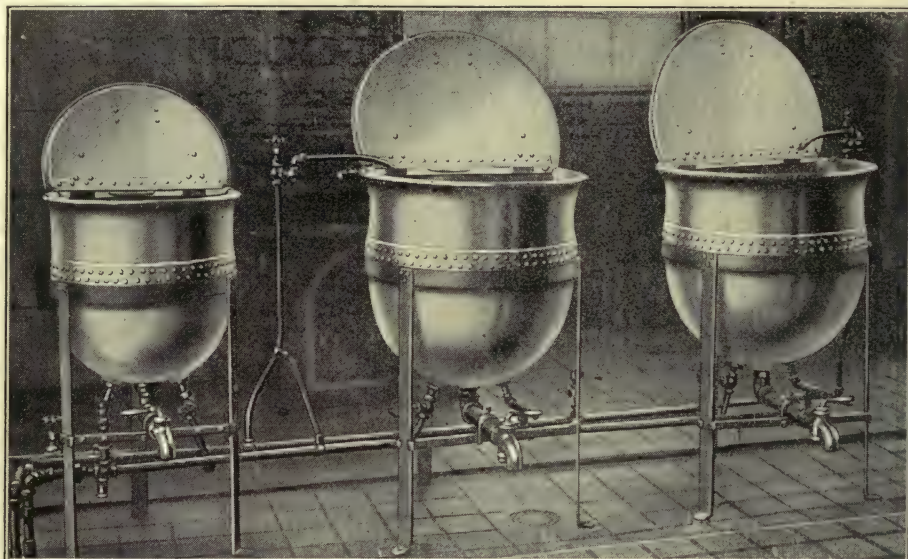
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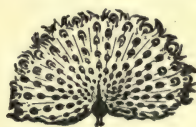
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire

Vol. XIX.

TORONTO, MARCH, 1921

No. 3

Editorials

SIR WILLIAM GAGE

THE passing of Sir William Gage has called forth tributes such as have seldom, if ever, been paid to any Canadian. From His Majesty the King down to the last wee tot to be admitted to the Queen Mary Hospital the sterling worth of a great philanthropist, his unfailing kindliness, and the debt which humanity owes to him both for what he did and for what he inspired others to do, have been fittingly and gratefully remembered.

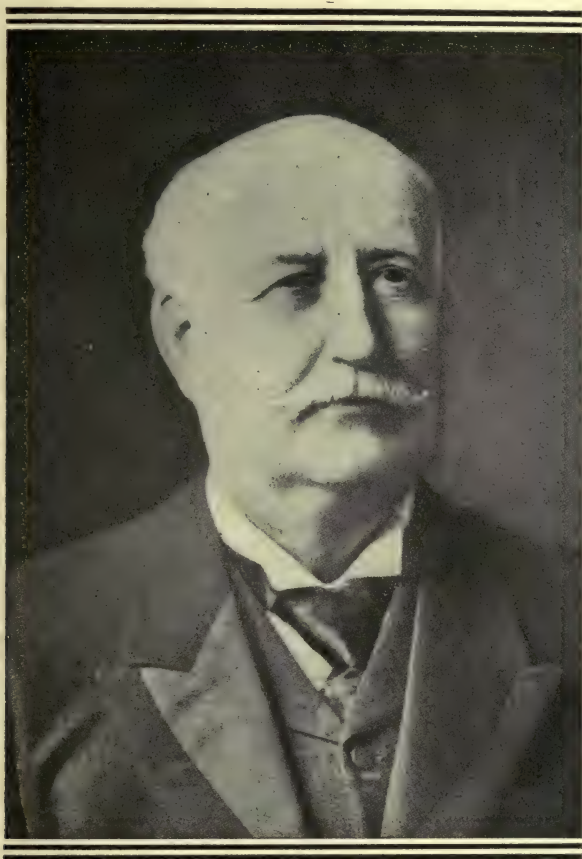
Somewhat more than twenty-seven years ago my co-trustee, Mr. Hugh Blain, then President of the Board of Trade, made the suggestion that the time was ripe for doing something to help those of our people who were stricken with tuberculosis. Following up this idea Mr. Gage shortly afterwards made an offer of \$25,000 to the City Council to build a sanatorium. The sole condition attached was

that the institution when built should be efficiently maintained. No official action followed this offer. About this time Fred Victor Massey fell a victim to the disease and this gave me an opportunity to suggest to his father, Hart A. Massey, whom I was attending, that he should join Mr. Gage, and by a gift of an equal amount make it possible for that gentleman to undertake at once the erection of a sanatorium in Muskoka. An interview between Mr. Gage and Mr. Massey led to the first sanatorium movement in Canada—a movement which has developed until more than 15,000 patients have been cared for, until about 700 are constantly being cared for, and until more than \$1,500,000 has been invested in this humanitarian effort.

From the beginning those of us who have had the high privilege of being associated with Sir William Gage have felt his wise and far-seeing leadership. We came to know and to honor his fidelity to the highest ideals of service. Friendship for him deepened year by year and ripened into love such as no man wins who is not worthy of it. Last spring, as my car entered the grounds of the sanatorium at Weston, my companion, noting its splendid circle of buildings, said to me, "Isn't it a dream?" and I replied, "Yes, and behind the dream is the man of vision who is making the dream come true." Thank God for men like Sir William, who build their love for humanity into bricks and mortar!

The world knows something of what Sir William Gage was as a business man, and of what it was

given to him to accomplish. We, who were his intimates, gladly recall that his home life was ideal. As regards both wife and children he was fortunate



THE LATE SIR WILLIAM GAGE

far beyond what is the common lot of mankind. The lover was never lost in the husband, and to his daughters he was father and brother combined.

In this life the faith of a man and the character which it helps him to develop are of supreme importance. Sir William's faith was simple and direct. To him theological discussions and the differences of denominations were distasteful. He knew in Whom he had believed and responded instantly when I once mentioned the words of Oxenham:

"Not what, but Whom I do believe,
For Christ is more than all the creeds,
And His full life of gentle deeds
Shall all the creeds outlive."

His own faith came to him at his mother's knee—surely God's holiest altar on this earth. It guided him for the full span of seventy years of wonderful service and it sustained him when all else around was failing. Can we doubt that in the land which knows no shadows his welcome was:

"Ye served your brethren; ye have served your Lord"?

N. A. P.

HOW TO MAKE HOSPITALS SELF-SUSTAINING

THE clinic in the cornfields has proved a grand success, and shows that when medicine and surgery are practised conscientiously and faithfully by well-posted and skilled men, they can stand on their own feet. This wonderful clinic, with its diagnosis building, hospitals and hotels for convalescing, has not to beg for subscriptions from the plutocrats,

some of whom hope to put themselves right in the public eye or salve their consciences by their contribution, nor has it to beg for doles from the bourgeoisie.

Here is a lesson for our hospitals. Employ only A1 men on the medical staff. Pay them as the Mayos pay their staff. Supply them with laboratories and plenty of equipment. Then demand WORK. Results will be sure to follow.

Hospitals who employ part-time men and pay them nothing cannot expect to get the same type of work as that done at the clinic—"away up yonder in de cornfields."

TRUSTEE BOARDS

MEMBERS of Hospital Trustee Boards are usually very busy men—good business men and charitably inclined. Some of them possibly serve for conscience sake. Heaven knows.

The president or chairman of the Board should be an undoubted leader. Some hospitals are one-man affairs, in so far as trusteeship is concerned, the other board members being mainly figureheads. This is particularly the case where the chairman, himself, puts up most of the money. As a rule his colleagues allow him to "run the show." Appointments of the executive heads are virtually made by him, and with him often lies the responsibility for much of the capital expenditure. As he pays the

piper he is allowed to call the tune. Ere long this sort of thing will be *non est*. It is not the democratic idea. Meantime let us be thankful for the benevolent autocrat.

Every Trustee Board should have a few committees. If the Board is large, there should be an executive committee; all of its actions, of course, should be ratified by the Board.

The finance committee is an important one in the average hospital board, as upon its vigor depends the solvency and good business aspect of the institution. It is up to this committee to suggest and provide methods for raising income, and upon it devolves the duty of supervising all expenditure. This committee, in consultation with the superintendent, should prepare and present to the board a budget containing a list of sources of income, with probable amounts available; and also an estimate of the probable expenditures for the incoming year. If the hospital has a proper accounting system—and it certainly should have—the finance committee can keep a grip on expenditure of all leading items. In this way economy in purchasing is secured and extravagance in the use of supplies may be checked.

The house committee is an important one. It or one of its representatives should go through the institution at least weekly with the superintendent, and inspect the building from cellar to garret. Note should be taken of the physical aspect of the building—roof, walls, floors, windows, as to integrity and cleanliness. Furniture and fixtures should be

examined. The kitchen, sinks and garbage rooms should come under close scrutiny, as well as the laundry and power plant. An examination of the linen, the milk, meats, the coal, and supplies generally should be made. The general appearance of the employees should be noted. Are they tidy? Do they go about their duties with alertness? Are they respectful and careful? The pantries (or serving kitchens), sink rooms and appliance rooms should be examined with particularity. Are the dishes chipped? Is everything in its proper place and readily accessible? Do the employees work quietly?

Quite often an outsider who comes in weekly in this way will note things out of the way, which may have evaded the eye of the superintendent, be he ever so watchful.

In the larger hospitals various other committees may be required, but in one of our average institutions in Ontario, we would consider the executive, the finance and the house committees as *sine qua non*.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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Original Contribution

PROVINCIAL HOSPITAL ORGANIZATION IN CANADA

BY M. T. MACEachern, M.D., C.M.

General Superintendent, Vancouver General Hospital.

THE present day tends more and more to a "get-together" spirit—to communalize rather than individualize, accompanied by a desire for mutual co-operation. This is true in all walks of life. We realize that success means development along better and more efficient lines and demands true, unselfish service. It means more intercommunication between people, with exchange of ideas and efforts, to which can be applied such a motto as, "Service not Self." If we reflect for a moment on other walks of life, such as business, industrial, professional, educational, etc., we find organization, local, provincial and national in character. People following the same interests of life find it practical, and almost imperative, that they band themselves together for advancement, whether scientific, educational, financial or otherwise. There is power and force for development in organization, in addition to increased stimulation and enthusiasm aroused. The professional lines of work are now well organized, doctors, nurses, public health, social service and other activities in this category are doing wonderful work through their organization. Our hospitals, however, have lagged far behind and the day is at hand when we must organize for advancement purposes. We cannot argue against hospital organization if we want to develop the field, and our institutions will not progress, will not command public confidence, will not be a force in the public health education propaganda, unless they organize, provincially at least, and carry this out with earnestness. The self-satisfied institution that has no interest in the field outside of its own

community must be awakened to the newer idea and to its obligation of unselfish co-operation.

Provincial organization in Canada commenced in June, 1918, when a number of representatives from the hospitals of British Columbia assembled at Vancouver for a three-day convention. This was inaugurated by permission of the Board of Directors of the hospital which I serve. Here a most interesting programme was carried out, and almost all the hospitals were represented. Complete organization followed, and ever since this Association has been working actively. To-day The B. C. Hospital Association stands as an official authority on hospital matters in the province, and splendid team-work and mutual co-operation has followed. The Association has held annual conventions, steadily growing in size and influence. The next province to organize was Alberta, and shortly afterwards, Saskatchewan. Real live associations are found in both these provinces and annual conventions are being held. Recently Manitoba organized, with Dr. George Stephens, Superintendent of the Winnipeg General Hospital, as the first president. I understand Ontario has a Hospital Association, but I do not know what its activities are as yet. Coming to Quebec, I believe the groundwork is being most efficiently laid for a provincial association through Dr. A. K. Haywood, Superintendent of the Montreal General Hospital, he having fully organized the city hospitals into an association some time ago. I am not in a position to speak for the Maritime Provinces, but feel sure they will be to the front in this as they always are in other matters. Therefore we must conclude the idea of provincial hospital organization has taken root in Canada.

The prime object of this paper is to throw out a few suggestions that have been tried and found successful, in order that they may be useful to others desiring to organize. The question perhaps that confronts several provinces is: How shall they proceed to organize a provincial hospital association? This is not always easy, but I would suggest that the move be made by the largest hospital in the province, and it so happens that each province has one large hospital centre. For instance:

Nova Scotia has Halifax; New Brunswick has St. John; Prince Edward Island has Charlottetown; Quebec has Montreal; Ontario, Toronto; Manitoba, Winnipeg; Saskatchewan, Regina; Alberta, Calgary; and British Columbia, Vancouver. In all these cities are found the largest hospitals in the province. The superintendent and trustees of the institution must be good "sports" and start the work, possibly requiring considerable effort and a little expense for the initial meeting. A list of the hospitals can always be secured from the Provincial Secretary, and a series of circular letters sent out previously will work up the attendance better at the meetings. Here are a series sent out in our province:

April 15th, 1918.

Dear Sir or Madam:—

On investigation I find that there are over ninety hospitals in our province, varying in size from a few beds to many hundreds, and all carrying on similar work. Speaking to several hospital people from time to time I have learned that there are many difficulties and problems confronting the institutions almost constantly and that they are anxious for assistance in the solution of these. Realizing, again, the development and progress can only come from co-operation and team-work amongst our hospitals, I feel that there is great need for calling our hospitals together with a view to forming an active association for hospital development in our province.

Such an association, in addition, would be a clearing house for all matters concerning the hospitals of the province as a whole and could assist materially in matters determining policy or legislation. We find organization carried on in other walks of life—professional, business, educational, etc., and I feel that we should very seriously consider the same in connection with our institutions. There are at least five good reasons why we should organize:—

Firstly—To serve as a means of intercommunication and co-operation between the hospitals in British Columbia.

Secondly—To establish, maintain and improve standards of hospital work.

Thirdly—To promote the efficiency of all hospitals in the province.

Fourthly—To stimulate intensive and extensive hospital development.

Fifthly.—To make all hospitals of more community service.

This matter has been before the Board of Directors of The Vancouver General Hospital, and they have approved of the suggestion and will lend their assistance to the project in any way they can to make it a success. We are therefore anxious to arrange for a meeting this coming summer, to be held in Vancouver, at a suitable date to be selected.

Would you give this matter your serious consideration and send me an expression of opinion at your very earliest opportunity.

May 4th, 1918.

Dear Sir or Madam:—

Some time ago we wrote you regarding the holding of a Hospital Convention in Vancouver.

It is felt that there is great need of such a meeting once a year to discuss hospital problems and advances. There is also need of a provincial organization which can co-ordinate and deal with matters pertaining to hospitals from time to time, with the most beneficial results to all. We have, therefore, set aside June 26th, 27th and 28th as the dates for this convention. We have also arranged with the University of British Columbia to have their auditorium, which is on the hospital grounds here.

This convention will be open to hospital superintendents, trustees or directors, nurses and all others interested in hospital work.

The sessions will be devoted to:—Organization, papers and discussion, demonstrations, exhibits, commercial and non-commercial, entertainment.

Every effort will be put forth to make this convention a real live success, and will be of invaluable importance to all hospitals. The papers will all be practical, carefully selected and giving lots of opportunity for discussion.

We want you to send, as soon as possible, all your suggestions, and to give at least six or ten subjects that you would like to hear discussed. These will possibly involve something of interest and practical value to your hospital and many others. From the list thus received we can select the subjects to be discussed.

Round Table conferences will be held each day, to which you must bring your difficulties and problems. The demonstrations will be in Nursing, in Technic, in Laboratory work and other features. Dealers in hospital supplies will exhibit at the convention. Home-made appliances and equipment of all kinds will be shown. In short, all branches of hospital work will be covered.

Automobile trips will be arranged, and one afternoon be spent in a trip to The Royal Columbian and Provincial Mental Hospitals, New Westminster. On Friday night, June 28th, the convocation for nurses will take place in the auditorium, where sixty nurses will graduate.

Every hospital must be represented by as many people as possible. We are going to a great deal of trouble, and we only ask in return that we have a good audience, and that we have your presence and that of as many more as possible from your hospital community.

Answer as soon as possible.

May 23rd, 1918.

Dear Sir or Madam:—

The importance of your hospital in the community should concern everybody. Your hospital not only stands for the care and treatment of patients confined within its walls, but it has another duty to perform, inasmuch as it should do everything to efficiently promote the health of the community. The great value of hospitals is now more apparent than ever, especially as a large number of them will have to do a great deal of war work. Therefore it is very important that you and as many more from your hospital community as can, will attend our convention as arranged for June 26th, 27th, and 28th.

Many hospitals have responded and are sending delegates. Many subjects have been received. We beg to report splendid

progress in the arranging of this convention. I am enclosing herewith a general outline of the programme which, of course, is not final, but may be modified from time to time. This indicates that we will have a very full programme. We have not selected the subjects yet, as we are still waiting to hear from a number of hospitals. We would like to have volunteers to give papers, and if there is any person willing, I am sure we would be glad to know at once.

All arrangements are proceeding most satisfactorily. A full line of hospital supplies, commercial and non-commercial articles, will be shown. Dr. Mullin, Director of Laboratories, Vancouver General Hospital, will take up the question of the Hospital Laboratory, and will endeavor to demonstrate and tell you how you may all do the necessary laboratory work in your hospitals without having trained technicians. Dr. F. T. Underhill, Medical Health Officer, City of Vancouver, will take up many practical points and problems from a health standpoint. Hon. J. D. MacLean, Provincial Secretary, and Dr. H. E. Young, Secretary of the Provincial Board of Health of Victoria, have been invited to give addresses. The programme, therefore, is going to be most interesting.

Please remember that this convention is not for hospital superintendents only, but particularly for trustees and directors, and let us say again, everybody from your hospital community who are interested in such good work.

If you have not answered my letter of recent date, please do so as soon as possible.

June 3rd, 1918.

Dear Sir or Madam:—

This is the third communication which you have had from me regarding the hospital convention. You will find enclosed herewith a postcard already stamped, which I trust you will fill out as soon as possible and return. We want this convention to be the most representative of any ever held in the province.

The subjects, as you will see by the enclosed circular, are of vital interest, and we are going to accomplish a great deal at this meeting. You do not need to come feeling that you will

not have to work, because every subject will demand your most serious and thoughtful consideration, as well as discussion. Every person that attends this convention will have a chance to talk and say all they can, but, of course, they will be limited to a few minutes at a time. As the programme will be exceedingly heavy, we must have every session commence sharp on time and the delegates present. Most conventions drag along with not enough enthusiasm, but in this one we are going to prevent that.

You will note that the convention ends on Friday afternoon, but that you are all most cordially invited by the Superintendent of Nurses, the Board of Directors, and myself, to the Convocation exercises and dance following.

Owing to the full programme, very little time has been allotted to visiting hospitals in Vancouver, but we hope to make arrangements during the session or on Saturday, if anybody can remain over, to show the delegates through the various hospitals in the city. However, the convention badge will admit you to anywhere in any institution in the city.

As to accommodations, there will be no difficulty in obtaining same in the city, as there are numerous good hotels.

Many prominent speakers will address the Association. Mayor Gale has consented to open the convention sharp at ten o'clock on Wednesday, June 26th, and deliver the civic address of welcome.

If there are any questions or any suggestions, I shall be very pleased to receive them at any time.

June 15th, 1918.

Dear Sir or Madam:—

Delegates to the convention can secure accommodation at the following hotels: Vancouver Hotel, Glencoe Lodge, Duns-muir Hotel, Grosvenor Hotel.

In the next block to the University auditorium, where the convention will be held, is a splendid cafeteria, run in connection with the King Edward High School, where lunch can be secured by any of the delegates who desire to do so, and thus

save time required to go down town between the morning and afternoon sessions.

Already seventy delegates have signified their intention to be present.

June 19th, 1918.

Dear Sir or Madam:—

On June 26th, 27th and 28th, we propose holding a convention of hospital superintendents, nurses, trustees and other people interested in this branch of work. The object of this meeting will be to take up matters pertaining to administration, hospital problems, hospital advances, etc., for which we feel there is a great need at present, owing to our country being at war, and many of our hospitals having to do a great deal of war work. I dare say that the same conditions and the same problems confront the hospitals throughout the State of Washington, and on this account I desire to extend an invitation to all hospitals in your State, to include superintendents, trustees or directors, nurses and all others interested in hospital work. The sessions will be devoted to: Organization, papers and discussion, demonstrations, exhibits, commercial and non-commercial, and entertainment.

Every effort will be put forth to make the convention a real live success and will be of invaluable importance to all hospitals. The papers will be practical, carefully selected and giving lots of opportunity for discussion.

Round Table conferences will be held each day, where all difficulties and problems will be taken to be discussed. The demonstrations will be in nursing, technic, laboratory work and other features. Dealers in hospital supplies will exhibit at this convention. Home-made appliances and equipment of all kinds will be shown. In short, all branches of hospital work will be covered. Automobile trips will be arranged, as well as other entertainment and visits to hospitals.

It is felt that a great many of the hospital administrators cannot get East each year to the large conventions held in Eastern cities, and possibly by getting together, some benefit can be attained to help in hospital administration and make our institutions better.

June 21st, 1918.

Dear Sir or Madam:—

This is the last communication you will receive from me before we meet at the convention. There are a few things which I want you to endeavor to do.

First of all, come to the convention, not only one, but as many as possible from your community.

Secondly, come prepared to join in all the discussions and give the very best of your opinion on the various subjects.

Thirdly, endeavor to be at the convention hall by 10 a.m., Wednesday, so that His Worship the Mayor of the city will be able to address as large a convention audience as possible.

Fourthly, endeavor to be on time for all sessions. You will see by the enclosed programme that unless the papers are started sharp on time we will never get through, and therefore, it is important to be ready to start sharp on time each day and each session.

Fifthly, register first on your arrival at the convention hall and secure your badge.

Again I urge that there be a good attendance, as the Board of Directors of the Hospital and myself have gone to a great deal of trouble to make this occasion profitable and pleasant, and we are all looking forward to it as a most useful "get-together" meeting of the hospitals of British Columbia.

Hoping to see you all next week,

Yours very truly,

M. T. MacEachern, M.D., C.M.

General Superintendent,

Vancouver General Hospital.

Such letters as these will serve in getting the hospital people interested and worked up to come to the meeting, bringing all who are in any way interested in this work. Invitations should be sent out regardless of type of institution—private, public or religious. All should be called together, being there

to serve the same cause, whether Catholic or Protestant, they can and must work together. You must fulfil your promise, however, by a real interesting and practical programme. It may be necessary that the programme for the first convention be compiled almost entirely from the community calling the meeting, but in so doing, care should be taken to protect the viewpoint, needs and interests of the smaller hospital, and at no time **must** the provincial organization give the impression that it **exists** for the larger institutions. The reason for this is the fact that most of the hospitals are much smaller in size and being rural in location, their problems are many. The provincial organization should be primarily for the smaller hospitals.

I have also found that it is best to send all communications to the Secretary of the Board of Trustees, rather than the Superintendent, for in so doing it becomes an official piece of correspondence, and is always sure to get to the right source. It is not so much the superintendents we want to get interested in these hospital meetings, as the boards of trustees and other people not so directly in touch with the institutions.

The objects of such an Association as this can be as follows:

- (a) To serve as a means of intercommunication and co-operation between the hospitals in British Columbia.
- (b) To establish, maintain and improve standards of hospital work.
- (c) To promote the efficiency of all hospitals in the province.
- (d) To stimulate intensive and extensive hospital development.
- (e) To make all hospitals of more community service.

From such objectives as I have enumerated one can readily see the advantages. It means more intensive hospital progress from every possible angle and a provincial organization to handle all problems provincial in nature, such, for instance, as come up before the Legislature from time to time. Through the provincial Association the public can be educated up to

better financial advancement and development, as well as encouraging better team-work amongst our institutions. Finally, such an association can take its place as a unit in the National organization.

Any organization such as this requires by-laws and constitution. Several may suggest themselves, but I am going to take up with you one which has proved successful. The by-laws and constitution of The B. C. Hospital Association are as follows:—

CONSTITUTION AND BY-LAWS FOR THE B. C. HOSPITAL
ASSOCIATION

Article 1—Name.

The name of this Association shall be "The B. C. Hospital Association."

Article 2—Purpose.

It shall be the purpose of this organization:

- (a) To serve as a means of intercommunication and co-operation between the hospitals in British Columbia.
- (b) To establish, maintain and improve standards of hospital work.
- (c) To promote the efficiency of all hospitals in the province.
- (d) To stimulate intensive and extensive hospital development.
- (e) To make all hospitals of more community service.

Article 3—Officers.

The officers shall be:

Honorary President.

President.

Vice-President.

Secretary.

Treasurer.

Executive Committee of Ten.

Article 4—Membership.

The members shall be all persons connected directly or indirectly with hospitals paying the membership fees hereinafter mentioned, and such members shall be classified as follows:

- (a) Active.
- (b) Associate.
- (c) Honorary.

- (a) "Active" members shall include all who are actively engaged in hospital work, and this means on the regular staff of the hospital.
- (b) "Associate" members shall include all who are engaged in hospital work, but are not on the regular staff, and shall include attending doctors, nurses, members of trustee boards and hospital auxiliaries.
- (c) "Honorary" members shall be the active and associate members who have ceased to take active part in hospital work after years of faithful and recognized service.

Article 5—Election of Officers.

This shall take place at the annual meeting each year, and shall be by ballot. All officers shall be elected for a term of one year.

Article 6—Executive Committee.

The Executive Committee shall be composed of the officers and ten other members, elected from the Association at the annual meeting.

Article 7—Quorum.

Five members shall constitute a quorum of the Executive Committee, which shall meet at least once a year, and at other times at the call of the chairman or any five members. Ten per cent. of the members shall constitute a quorum of the whole Association. The Executive Committee shall carry on the affairs of the Association during the year and report to the Association at the annual meeting.

Article 8—Meetings, Time and Place.

The annual meeting of the Association shall be held at the time of the Hospital Convention, notice of which shall be sent out to each member one month in advance. The place at which the annual meeting and convention shall be held will be decided on at the annual meeting or convention of the previous year.

Article 9—Amendment to By-laws.

By-laws may be amended at any regular meeting by a two-thirds vote of members present.

Article 10—Recommendations.

All recommendations and suggestions must be sent in in writing to the Secretary of the Association, who shall lay same before the Executive for discussion and consideration previous to the annual meeting of each year.

Article 11—Membership Fees.

All hospitals paying the following fees shall be entitled to membership in this Association:

1. Hospitals of ten beds or under, \$5 per annum.
2. Hospitals of ten to twenty beds, \$10 per annum.
3. Hospitals of twenty to fifty beds, \$15 per annum.
4. Hospitals of fifty to one hundred beds, \$20 per annum.
5. Hospitals over one hundred beds, \$25 per annum.

(These by-laws are being amended now so as to arrange for better representative voting than formerly).

In the selection of officers and executive for a provincial association an executive should be secured which is representative, and this, in our particular province, has resulted in geographical selection; thus the rural and city are fairly represented on the executive, which carries on all the business between the annual meetings. This executive may also be required to interview the Legislature or other bodies on important matters, and possibly will necessitate holding one or two meetings each year.

It is always wise for the meeting to be held in different places each year, so as to go its rounds as much as possible, for it carries fine propaganda into each district and this stimulates more local interest, which is of value to that particular hospital.

Programmes must be well arranged and practical, with lots of time to be devoted to discussion, questions and answers or round table conferences. The Association should act as a clearing house for all difficulties and hospital problems of the province. Here are some very valuable subjects which have been discussed at some of our past conventions:

Hospital Standardization.

The Hospital—Past, Present, Future.

The X-Ray Department.

Problems of the Hospital in Outlying Districts.

Small Economies in Hospitals.

Hospital Architecture.

Standardization of Hospital Equipment and Supplies.

The Hospital as a Community Service.

The Public Health Problem of the Province.

The Tuberculosis Problem of the Province.

The Elimination of Chronic Hospital Cases by Proper
Dental Diagnosis and Treatment.

Financing the Hospital.

Hospital Accounting.

The Hospital Laboratory.

The Standardization and Affiliation of Training Schools
in British Columbia.

The Modern Trained Nurse.

The Food Problem of To-day as it Affects the Hospital.

The Hospital Dietary.

The Assistance of Publicity to the Hospital.

Maternity Work in the Small Hospital.

The Hospital Pharmacy.

The Administration of Anesthetics.

The Standardization of Training Schools in British Col-
umbia.

Post-graduate work.

Case Records in Hospitals.

A New Basis of Financing Hospitals.

The Relation of the Women's Auxiliary to the Hospital.

Hospitals and Tuberculosis.

Nursing Standards.

The University in Relation to Nursing Education.

The Shortage of Applicants for Training.

Nursing service in hospitals of twenty-five beds and under:

(a) Nursing by graduates only or by nurses-in-training.

(b) If by pupil nurses, how can their training be broadened?

By affiliation.

By travelling instructors.

By specially-planned curriculum.

(c) Could ward assistants be utilized in small hospitals, and if so, what work could be given them?

Survey Report of Hospitals.

Survey Report of Hospital Standardization.

Hospital Dietetics in Relation to the Scientific Treatment of Disease.

Organization and Management of Hospitals and service to be expected in:

(a) Hospitals up to twenty-five beds.

(b) Hospitals twenty-five to fifty beds.

(c) Hospitals fifty beds and up.

Medical service in hospitals of five to one hundred beds:

(a) The Clinical Laboratory, its equipment and operation.

(b) The X-Ray Laboratory, its equipment and operation.

(c) Medical case records, importance and how acquired.

(d) Relation of the Medical Staff to the Hospital.

Hospital Planning.

Standardization of Hospital Accounting.

Hospital Financing:

- (a) Financial problems of hospitals to-day.
- (b) Sources of revenue and expenditure.
- (c) Uniformity of hospital charges—ward fees; special charges for extras; contract charges.

The Hospital and the Public Health Nurse in the Rural Community.

You will ask who should attend these conventions, and I would say, all who are connected directly or indirectly with the institution, or broader, all those who are interested in the work of the hospital. Meetings should be held, giving the public an opportunity to attend, and in this I would suggest evening meetings, when a carefully arranged programme of general interest can be given.

In our Association we find it very valuable to have special and standing committees. The special committees are such as:

- Committee on Arrangements.
- Committee on Resolutions.
- Committee on Officers, Time and Place of next meeting.
- Committee on Development.

Throughout the year we carry three standing committees, namely:

- Business Committee.
- Nursing Committee.
- Medical Committee.

These committees look after their own respective matters which come up during the year, and act as bureaus of information for all hospitals.

In conclusion, let me urge provincial hospital organization in Canada. We must push ever forward; we must develop; we must be constantly conscious of our serious obligation as hospital workers—the care of a sacred trust; and to do this we need the stimulation and inspiration of a real active provincial hospital association. Therefore, I trust before the conclusion of this present year every province in Canada will have a real active provincial hospital association.

THE AMERICAN HOSPITAL ASSOCIATION

QUARTERLY MEETING OF TRUSTEES

At the last quarterly meeting of Trustees, the following were the subjects discussed:—

1. ANNUAL CONFERENCE FOR 1921.

Time—September 12th to 16th, inclusive.

Place—West Baden Springs Hotel, West Baden, Indiana.

2. The trustees expressed the desire to continue the hotel type of convention as long as possible, but recognized that the growth of the Association would soon make the auditorium type necessary.

3. A representative of the Surgeon-General, United States Public Health Service, was heard, on the question of the judicious opening of general hospitals to certain types of cases of pulmonary tuberculosis. A resolution was passed recommending that whenever practicable and feasible general hospitals open separate wards for these cases.

4. Upon proper application filed the Michigan Hospital Association was accepted as a geographical section of the American Hospital Association for the State of Michigan.

5. On account of the fact that the Constitution provides for geographical and departmental sections only, the application from the Protestant Hospital Association for recognition as a section was necessarily tabled for lack of authority to act. The trustees expressed, however, general interest and approval of the work of the Protestant Hospital Association as planned by its officers, and wish to establish with this Association the same friendly relations as are already established with the Catholic Hospital Association. The basis of this understanding is the recognition of the fact that the Catholic Hospital Association is performing a distinct service in the development of the

hospital field such as is in general the work of the American Hospital Association, but doing this particular work much more effectively than the American Hospital Association ever could have done.

6. *Service Bureaus*.—Some definite plans for work and for the publication of material developed by the service bureaus were approved.

7. The report of the committee which made the study of Hospital Social Service was approved.

8. A gift of \$1,000 toward the expense of a study of hospital flooring was accepted with appropriate expressions of thanks, and Mr. F. E. Chapman, Superintendent, Mount Sinai Hospital, Cleveland, Ohio, was appointed the chairman of the committee to carry on this work. Other members will be added to this committee as the development of the work indicates.

9. A resolution was passed urging hospitals to secure more autopsies.

10. Two new sections were authorized to be developed as the interest in our membership shall dictate.

(a) A section on Hospital Dietetics.

(b) A section on State or Psychopathic Hospitals.

11. The trustees passed a resolution urging the Hospital Associations in the various provinces of Canada to apply for recognition as geographical sections under the terms and arrangements authorized for geographical sections.

12. The subjects for several future Bulletins were approved.

13. The question of the proposed increase in duty (United States) on several items of hospital supplies were discussed at length, and the Executive Secretary was authorized to appear at the hearing on these bills held by the committees in Washington; and to take definite positions in this matter.

14. Quite a number of suggestions as to the development of the organization of the Association and its service to hospitals were discussed at length and definite policies determined.

STANDING COMMITTEES, 1921.

Constitution and Rules.

- Mr. R. P. Borden, Chairman, Union Hospital, Fall River, Mass.
Dr. R. B. Seem, Director, Albert Merritt Billings Memorial Hospital, Chicago, Ill.
Dr. A. K. Haywood, Superintendent, Montreal General Hospital, Montreal, Quebec.

Nominations.

- Dr. W. L. Babcock, Chairman, Superintendent, Grace Hospital, Detroit, Mich.
Mr. A. B. Tipping, Superintendent, Touro Infirmary, New Orleans, La.
Miss Mary L. Keith, Superintendent, Rochester General Hospital, Rochester, N.Y.

Legislative.

- Mr. F. E. Chapman, Chairman, Superintendent, Mount Sinai Hospital, Cleveland, Ohio.
Dr. R. G. Broderick, Director of Hospitals, Alameda County Hospital, San Leandro, Cal.
Mr. Pliny O. Clark, Superintendent, Presbyterian Hospital, Denver, Colo.

Membership.

- Dr. C. W. Munger, Superintendent, Columbia Hospital, Milwaukee, Wis.
Mr. Howard E. Bishop, Superintendent, Robert Packer Hospital, Sayre, Pa.
Miss Myral M. Sutherland, Superintendent, Mary McClellan Hospital, Cambridge, N.Y.

Time and Place.

- Dr. L. H. Burlingham, Chairman, Superintendent, Barnes Hospital, St. Louis, Mo.
Mr. H. E. Webster, Superintendent, Royal Victoria Hospital, Montreal, Quebec.
Miss Mary M. Riddle, Superintendent, Newton Hospital, Newton Lower Falls, Mass.

Out-Patient Work.

- Mr. John E. Ransom, Chairman, Superintendent, Michael Reese Dispensary, Chicago, Ill. Term expires Convention 1922.
Dr. Robert J. Wilson, Director, Health Department Hospitals, New York City. Term expires Convention 1921.
Dr. Alex. H. Thompson, Director, Department of Medical Activities, American Social Hygiene Association, 105 W. 40th Street, New York City.

Study of State Subsidy for Hospitals.

- Mr. Howell Wright, Chairman, Executive Secretary, Cleveland Hospital Council, Cleveland, O.
Dr. Winford H. Smith, Superintendent, Johns Hopkins Hospital, Baltimore, Md.
Mr. Daniel D. Test, Superintendent, Pennsylvania Hospital, Philadelphia, Pa.

Canadian Hospitals

SIR JOSEPH FLAVELLE AND MR. P. C. LARKIN RETIRE

WITH great regret the trustees of the Toronto General Hospital have received the announcement that both Sir Joseph Flavelle and Mr. P. C. Larkin have decided to give up the chairmanship and vice-chairmanship, respectively, of the Board of Trustees.

This announcement, following as it does the resignation of Mr. W. E. Rundle from the chairmanship of the finance committee after seventeen years' service, marks the breaking up of the board which gave the splendid institution on College street to the city.

High tribute is paid to the services of Sir Joseph Flavelle in connection with the hospital by his co-trustees. Mr. P. C. Larkin stated that for many years Sir Joseph had devoted more time and attention to the hospital than he had to his own personal affairs.

Mr. Larkin said: "The bronze tablet that has been erected in the main hall of the General Hospital has been, as the inscription says, placed there by the members of the Board of Trustees to commemorate the great work of their chairman. The great mass of buildings erected on College Street on nine acres of land and devoted to the taking care of the sick, is a monument to the energy, foresight, perseverance, resource and munificence of the chairman of the board. These buildings are now at the service of the city and province entirely free from debt.

"I recently retired from the vice-chairmanship of the board because the work has grown too heavy, and I am extremely sorry to hear that the chairman has now decided also to give up the position of chairman that he has occupied for nineteen years.

"When I joined the board eighteen years ago, the board consisted of four members, and they were four earnest, hard-working men. The hospital work was then carried on in buildings that were not only inadequate from their capacity, but they were in anything but a state in which to carry on modern hospital work.

"One of perhaps the greatest works done by a modern hospital is its outdoor clinics, where people in a large city can come by the thousands, as they do now in the new hospital, and be treated freely if they cannot pay a small sum. We had, in the old buildings, utterly inadequate accommodation for this important work. The buildings were without a single laboratory, they were very old and extremely dangerous, for, if a fire had taken place at any time, it would likely have cost very many lives.

"Sir Joseph well knew all these dangers and deficiencies, and when he was elected chairman at once determined that a new group of buildings should be erected and in a more central locality. His ideas were quickly shared by the other three members of the then board. At once rich men were approached to subscribe. The chairman was indefatigable, not only in personal interviews with people and in the getting of large subscriptions, but in getting meetings together and arranging committees, and so carrying on the work with such resource that eventually we had cash and promises to pay to an amount that warranted the board in looking out for locations. The College Street site was at last settled on, from many points of view it proving the best, especially that of being within reasonable distance of the university.

"The time, care and worry that all this work involved on the part of the chairman no one can appreciate who was not closely associated with him throughout. The results of his efforts are not only shown in the immense pile of buildings that everyone can see, but also in the less obvious thousands of people who have been cured of disease or benefited by treatment in the institution to which he has devoted so much of his life."

"For twenty years Mr. P. C. Larkin has given unremitting service as vice-chairman of the Board of Trustees of the General Hospital," said Sir Joseph Flavelle, chairman of the Board, in paying tribute to Mr. Larkin, "and in this capacity has rendered invaluable help. He made the comfort and care of the patients in the public wards of the hospital a matter of peculiar and constant concern. He took great pride in the physical care of the buildings and plant, and much of the excellence of the hospital in this respect is due to his insistent attention.

The members of the Board at the meeting, in expressing their deep regret at his firm decision to refuse re-election, bore testimony of his untiring and unassuming and consistent service which had been of such signal value to the trustees.

"It is a satisfaction to know that he will continue to be a member of the Board and will give his help in the work of the committees although he relinquishes the heavier duties associated with the vice-chairmanship."

Sir Joseph stated that Mr. Larkin's decision was due entirely to personal reasons and made it quite clear that no friction existed in connection with the hospital management.

With regard to Mr. Rundle's resignation, Sir Joseph says: "The trustees reluctantly accepted the resignation of Mr. Rundle as a member of the Board. Mr. Rundle has been chairman of the Finance Committee of the hospital for a period of seventeen years, and under his wise leadership and guidance, the heavy burden of financing the new hospital establishment has been accomplished.

"This great property is now free from debt, and can continue its beneficial services unembarrassed by annual charges for interest. It has been a fine work well done and Mr. Rundle will take pride in it.

"The citizens of Toronto, as well as the trustees of the hospital, will remember with gratitude the services Mr. Rundle has rendered. Mr. Rundle retires from the Board owing to the necessity of securing relief from too exacting duties and unfortunately he considered the hospital duties were those from which he could best be spared."

TORONTO'S NEW RECEPTION HOSPITAL

It would appear that after a long period of patience on the part of the citizens of Toronto the new Reception Hospital is practically assured. At a meeting of the City Council on January 24th, the site offered by the University of Toronto, conditional upon the institution being used as a Psychiatric Clinic, situated on Surrey Place, almost opposite Grenville Street, was approved. The site is estimated as being worth \$75,000, and the proposed building is to cost in the neighborhood of \$400,000. We are glad indeed to note that the work is to be proceeded with immediately, as such an institution has been sadly missed for the past year or more, many most deserving people suffering from incipient insanity having had to be confined in our jails until such a time as they were sent to one of the regular hospitals for the insane. The plan of the building at present under consideration is one that will meet with the approval, we think, of most hospital experts. The entrance will lead into a large corridor, off which will run male and female wards, and male and female admission departments. There will be plenty of provision made for light and everything in connection with the building will be up-to-date. The second floor will contain public wards for females, dining-room, recreation hall and bedrooms for the female help.

BRANTFORD URGED TO BUILD ISOLATION HOSPITAL AT ONCE

IN a statement given out by the local Health Department of Brantford, on Jan. 12th, it was pointed out that the city will have to proceed with the erection of the new isolation hospital, for which \$85,000 was voted, almost immediately in order to take care of the city's patients who should be in such an institution. It is expected that the City Council will be asked to proceed with the erection as soon as possible.

WALLACEBURG Memorial Hospital grant of \$10,000 was ratified by the County Council on January 29th.

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FIRE AT WHITBY HOSPITAL

A most unfortunate fire seriously damaged the new Infirmary of the Ontario Hospital at Whitby, on January 12th. Though the first reports were to the effect that the damage amounted to over \$100,000, we were glad to learn a little later that the total damage would not exceed \$3,500. The Government are now working upon the building and it is expected that it will be formally opened in the very near future. None of the other buildings were affected by the flames. It would appear that the loss would have been materially less had the fire-fighting apparatus at the hospital been in full function at the proper time. Into this aspect of the case the Government will conduct a careful inquiry.

We would like to congratulate Dr. Forster and his associates that the fire was not more serious.

W. A. CHARLTON SUCCEEDS THE LATE SIR WILLIAM GAGE

At a full board meeting of the trustees—National Sanitarium Association—held on February 2nd at the Gage Institute, Hon. W. A. Charlton, M.P., was unanimously elected to the office of president, filling the vacancy caused by the death of Sir William Gage, Mr. A. E. Ames being unanimously elected vice-president.

Mingled with a keen sense of great loss sustained by the Association, through the death of Sir William Gage, was the determination of every member of the board that the work should not suffer through lack of effort, it being felt that the greatest honor that can now be paid to Sir William's memory is to carry on the work which he so loved and in which he labored for so many years.

Plans are being prepared for the erection of a new Muskoka Free Hospital to take the place of the building recently burned, and a careful survey of the whole situation is being made with a view to carrying on the work in the most efficient manner.

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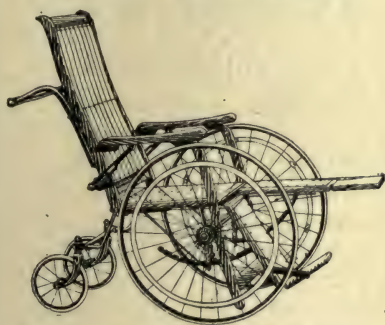
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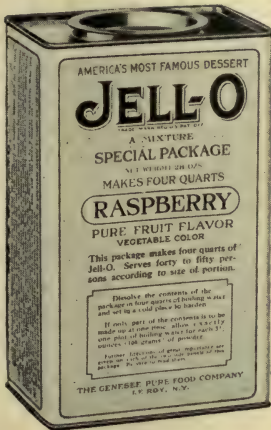
DEPUTATIONS from the different hospitals in Toronto appeared before the Board of Control on January 24th, in reference to grants to cover the different deficits. Arguments were put up by those interested to show that it was absolutely essential that, under present conditions, the Toronto City Council should come to the aid of those institutions who look after its sick. The matter was referred to the new Board of Control for consideration.

GEMS OF THOUGHT

THE delver into literature is sometimes rewarded by the discovery of passages in praise of tobacco which are real gems of thought in their smoothness of expression. Here is an example: "Within this magic warp and woof some potent, gracious spell imprisoned lies, that, when released by fire, softly steals within the fortress of the brain and binds in sleep the captured sentinels of care and grief." Another writer achieves the expression "the sun never sets on the cigarette," and it is indeed noteworthy that the cigarette is the world's favorite smoke.

THE GAMEWELL FIRE ALARM SYSTEM

THE HOSPITAL WORLD has never ceased to urge, as it does again in this issue, that all buildings in which the sick are confined should not only be fireproof, but should be equipped with the most satisfactory fire-extinguishing system, one which can be operated by individual members of the staff without delay or difficulty. The Northern Electric Company, Limited, are anxious that the merits of the Gamewell Fire Alarm System be carefully looked into as a fire preventative and life saver. It has been thoroughly tested and found to be all that the manufacturers claim for it. If more hospitals were thus equipped we would read of fewer fires and much less loss of life.



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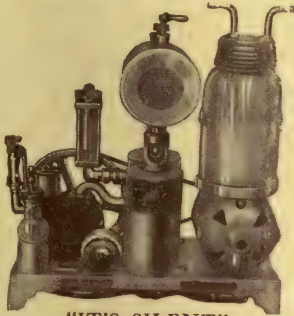
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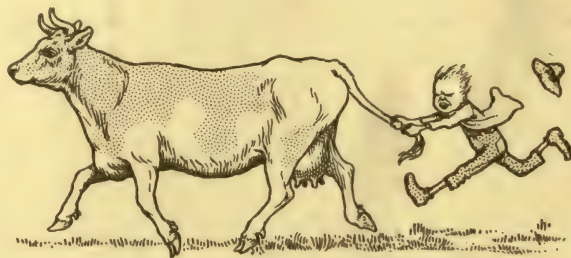
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THE HOSPITAL WORLD

Vol. XIX

Toronto, April, 1921

No. 4

CONTENTS

EDITORIALS

Public Health Nursing, Toronto.....	Page 109
Manager—Actor	114

ORIGINAL COMMUNICATIONS

The Hospital as a Public Utility. By J. H. W. Bower....	116
Canadian Hospital Construction.....	129

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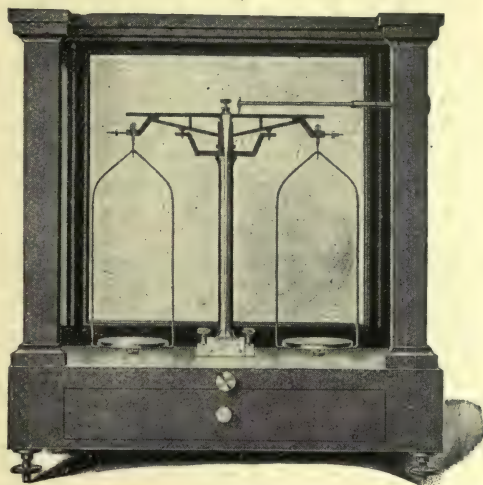
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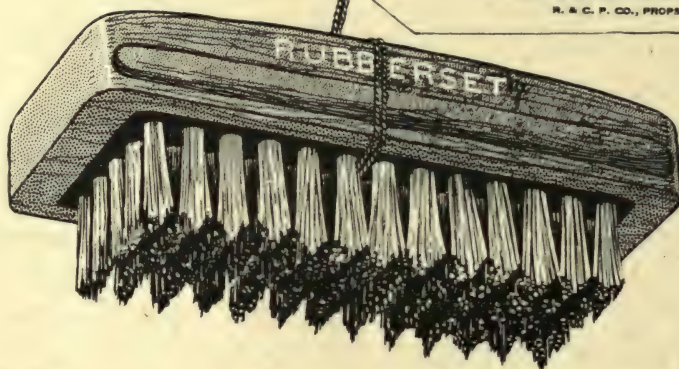
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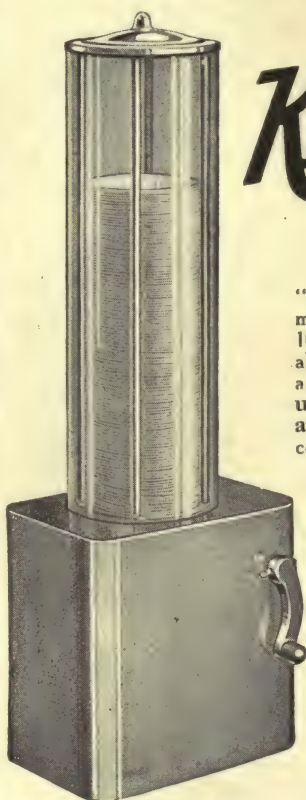
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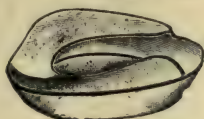
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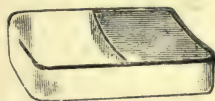
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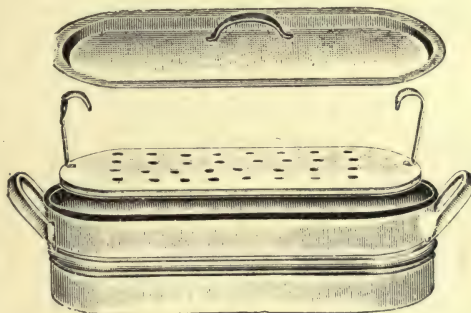
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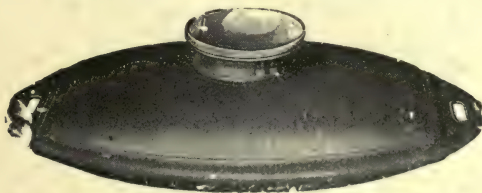
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire

Vol. XIX.

TORONTO, APRIL, 1921

No. 4

Editorials

PUBLIC HEALTH NURSING, TORONTO

ORIGIN.

IN 1907, at the request of the Toronto General Hospital, the first public health nurse for Toronto was appointed. Her work was exclusively among the tubercular. Shortly afterward St. Michael's Hospital secured a nurse for similar work. A branch for Child Welfare was established later. School nursing, which had been established in 1910, under the Board of Education, was taken over by the Department of Public Health in 1917.

STAFF AND DUTIES.

The Nursing Division of the Department of Public Health is under a director, who is responsible to the Medical Health Officer. The city is divided into

seven districts, with a superintendent in charge of each. There are about 100 nurses employed; and their work consists in school and district work. In the school the aim is to do both preventive and educative work. Their preventive work consists in the examination of all children absent two days or more, before admission to the classroom; fortnightly or monthly inspection of all classes and exclusion of suspect cases for diagnosis; they make provision for the correction of defects of vision, hearing, dental work, and attention generally to bodily ailments detrimental to the proper carrying on of studies. The educative aspect of the nurses' work consists in classroom talks on personal cleanliness and care of the body generally; proper diet; exercise; fresh air. Instruction is given to junior fourth girls in home and personal hygiene, care of the baby, with demonstrations of bathing and feeding.

Public health nurses also seek to enlist the aid of charitable organizations to supplement the work of the Public Health Department.

DISTRICT WORK.

Pre-natal Work.—The nurses visit the prospective mother, and urge her to keep in constant touch with her physician or a hospital clinic, at the same time instructing her as to the care of herself in respect to diet, cleanliness and rest and exercise.

Infant and Child Welfare Work.—Visits are made to the home of every new-born baby, and, where necessary, instructions are given the mother

how to care for it. Nurses attend child welfare clinics, to which the mothers are invited. Inspections are made of homes where babies are boarded, and also of maternity homes. Visits are also made to children who are absent from school on account of illness; and interesting parents in the correction of their children's defects.

Hospital Follow-up Work.—Visits are made to patients referred to the nurses by doctors conducting hospital clinics, through our hospital social service nurse. Necessary treatments which have been ordered are given. Patients are instructed in the correct way of taking treatments. Reports as to the patients' progress are made to the doctor. Visits are made to homes where a member of the family has been admitted to the Isolation Hospital; and instruction given regarding the detection of early symptoms of the disease which may appear in other members of the family.

Tuberculosis Work.—Visits are made to patients who have been discharged from sanitariums, and to those who have not had sanitarium treatment. They are instructed in the care of themselves and how to prevent infecting others. They also impress upon these patients the importance of keeping in touch with the hospital clinics or with their own doctor.

Social Work.—Where nurses discover families in need or distress of any sort through sickness or poverty, they make a report of the same to the Neigh-

borhood Workers' Association, which body takes steps to relieve the same.

Miscellaneous.—Investigations are made of complaints respecting improper housing, defects of plumbing, etc., and conditions reported to the proper division of the Department. Inspections are made of families previous to leaving for summer camps; ascertaining conditions for relief societies or associations; giving treatments at the request of the family physician when it is impracticable for patient to go to doctor for treatment or employ a private nurse or go to hospital.

Contagion.—In cases of suspected contagious diseases, visits are made to the family before sending a doctor to diagnose.

Epidemics.—Should there be outbreaks of influenza, smallpox, etc., public health nurses render what assistance they can.

Civic Employees.—Public health nurses are notified of the absence of all civic employees. Visits are made and reports sent, whether such absence is due to illness or not.

WORK OF SPECIAL SUPERVISORS.

There are six special supervisors.

1. *Infant Welfare.*—This supervisor organizes clinics in different districts of the city for pre-natal and infant welfare work; and attends such clinics at the Children's Hospital.

2. *Psychiatric*.—This nurse attends the psychiatric clinic, and does the follow-up work.

3. *School*.—This supervisor visits all schools—public and separate—and arranges work of school nurse.

4. *Venereal*.—This supervisor attends and supervises venereal disease clinics and does follow-up work.

5. *Hospital Extension Work*.—This supervisor is the Director of Nurse Education for the Department; supervises clinics of all the hospitals, except that of the Hospital for Sick Children.

6. *Tuberculosis*.—This nurse organizes and supervises tuberculosis work.

Maternity Homes.—This is under supervisor of Infant Welfare. This supervisor inspects all homes where babies are boarded or where mothers are confined, to ascertain if they are being properly conducted.

Students are sent from six of the Training Schools for Nurses in the city for a two months' experience in the work of the public health nurses.

RELATION TO OTHER DEPARTMENTS.

The work of the Public Health Nursing Division is related to that of certain other divisions of the Department. Records and statistics records are kept of all cases, active or inactive, which the Department has had to do with, and placed in their proper category. The Division of Communicable

Disease and Quarantine reports to the Nursing Division all cases of communicable diseases in school children. Nurses report back to this Division premises ready for fumigation, where that is advisable. Nurses frequently supply the Laboratory Division with specimens of sputum, urine, etc. From the laboratory are received the results of analyses and examinations.

—PHOEBE DODY, P.N.

MANAGER—ACTOR

MR. H. WYNN, manager of the Western Hospital, Montreal, is an amateur actor of long standing, and ranks as a "star" in the Community Players Club of that city. In one of Lord Dunsany's most successful one-act plays recently given by the Club, Mr. Wynn took the role of a deceased burglar who storms the gate of Valhalla by the aid of a "jimmy," and gains entrance.

A successful hospital manager is up against equally difficult official problems every day.

Mr. Wynn's fellow-workers will understand the reason of his realistic impersonation.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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Original Contributions

THE HOSPITAL AS A PUBLIC UTILITY

By J. H. W. BOWER.

Late General Superintendent, Engineering Branch, D.S.C.R., Hospital Consultant, Department Soldiers' Civil Re-establishment.

ECONOMIC CONSIDERATIONS ON DESIGN AND CONSTRUCTION.

CANADA during the war and post-war days has had, and is still having, many difficult and highly complex situations to face. In the work of "carrying on" during the war period, and during the period of reconstruction, social and industrial conditions have undergone tremendous changes.

The problem of rehabilitating ex-members of the forces in civilian life has perhaps been one of the most complex problems that Canada as a whole has ever faced. The work has received the untiring attention of professional men and laymen in every walk of life. Perhaps from the professional standpoint, the medical science has seen one of its greatest activities and periods of advancement known in history. The wonderful work of the medical man and the surgeon in the theatre of war has been the subject of general comment throughout the world. When sick and wounded men were returned from overseas, this wonderful work of human restoration was continued with equal efficiency in Canada.

It is not the intention here to discuss even in a general way the progress of medicine and surgery during the war and post-war period, but when it is considered that these activities reach such a final conclusion in institutions generally accepted as "temporary affairs," it would seem to follow that Canada's system of war hospitals requires some consideration toward perpetuating some of the ideas followed, in future civilian hospital work.

Practically every community throughout Canada feels the

present need of more hospital accommodation. Those who are responsible for the public welfare in this regard, while realizing the necessity, are loath to promote projects that would meet the situation on account of the enormous increase in constructional and material costs. Even before the war, the erection of hospitals and institutions involved expenditures that invariably raised the tax rate apparently out of all proportion to the facilities afforded. Only our larger cities seem to be able to finance the erection of institutions that would afford the most up-to-date facilities for taking care of the public at large.

One step toward solving the cost of institutional work required is seen in the movement toward the community hospital idea, namely, that of establishing a central institution to serve a number of neighboring municipalities. It is believed that this step is one in the right direction, and if the proper degree of co-operation is maintained, there is no reason why such projects cannot be promoted throughout the length and breadth of the country. To-day with our advanced facilities for transportation, the promotion of the good road movement, and the almost universal use of motor transport, the idea of a community hospital serving a number of municipalities is one which should give many of the desired results.

There is another phase of institutional work which in these days of monolithic structures seems to have been passed unnoticed by those who are most affected. Civilian hospitals erected in pre-war days have generally been of the "monolithic" and multiple storey type, located in down-town sections of municipalities, consequently surrounded by the rush and bustle of everyday life. Canada's war hospitals, which represent an accommodation in the neighborhood of 20,000 beds, have been commented upon most favorably by those in a position to criticize as obtaining all of those features of utility, both from the medical and the administration side, that go to make up a most efficiently working hospital machine. Their locations are, in most instances, somewhat removed from the hurry and scurry of everyday life. In general, their buildings consist of structures only two storeys in height, which of course necessitated the erection of buildings on the unit plan, all being properly related to central administration and operative units.

Canada's type of war hospital was evolved after a most careful consideration had been given to the problem, and the inception of the scheme was largely on account of the necessity of keeping constructional expenditures at the absolute minimum. During the operation of these institutions other considerations have become patent, and it has been found that their operation and general upkeep have been administered with just as much ease, and possibly more economically, than hospitals for civilian purposes erected in pre-war days.

When it is considered by those responsible for the running of these institutions that their maintenance, upkeep, and general patient day costs do not exceed, and are perhaps less than, similar costs in civilian institutions, and when this consideration is coupled with the fact that the capital expenditure involved approximates less than fifty per cent. of what ordinary institutions cost in pre-war days, one is immediately faced with the possibility that here is an object lesson, a careful study of which may lead to the solving of the difficult problem of providing Canada with sufficient institutions to properly meet the needs of its population.

It is true that institutions for civilian work would have to embody certain constructional features that do not pertain to war hospitals, but the general scheme of lay out and storey height of buildings is one which should receive very careful consideration at the hands of the architect who is called upon to make economical expenditure of public funds in the provision of institutions. The following report deals in a general way with the considerations referred to herein, and was presented before a hospital board which has been considering for some time the erection of a hospital. There has been no attempt to go into the matter in great detail, but the writer has endeavored to show that bricks and mortar do not materially furnish aid toward the recovery of the patient, and that injudicious expenditure in this regard is entirely unwarranted. It will be noted also from the report that this trend of thought is being entertained more and more by experts on this continent and in Europe, who have been intimately associated with institutional work.

A hospital is not a luxury; it is an absolute necessity. Such being the case, the public cannot afford to indulge in undue expenditure as to erection and upkeep costs. The problem, therefore, that confronts the designer in dealing with the matter of hospital design is indeed a very difficult one, and he who loses sight of any of the economic phases of the problem and enters into an elaborate and expensive type of construction is certainly failing to fulfil one of his most important functions. Consequently the architect must of necessity not only be the designer of the institution, but he must at the same time assume the position of adviser, in so far as his professional technical qualifications permit. It is impossible for any architect to assume such a position, no matter how well versed he may be in the criteria of hospital design from the standpoint of architecture, unless he has made himself thoroughly conversant and is personally familiar with the many and varied problems that arise in reference to matters of hospital management, the trend of thought of medical experts, and the probable considerations that will arise in the future.

A general hospital is a common utility, and as such should successfully serve the public. Therefore, it is not the excessively poor, or the rich proportion of the population that has to be primarily considered. The poor man who is unable to pay is, or should be, looked after by the State. The rich man is in a position to obtain that for which he is willing to pay. It remains, therefore, for the designer to construct a building at such a cost as to first expenditure and upkeep charges as will permit of the middleman, who is too proud to accept charity and too poor to pay excessive prices, taking such measures as will ensure the continued health of himself and his dependents.

It has been remarked that it is not only the pain and suffering that the average person fears in considering going to a hospital, but it is also the fear that he will be financially embarrassed for a twelvemonth in meeting his bills.

I think that the recent "Flu" epidemic demonstrated to those who actively engaged in gratuitously helping those unfortunates who were affected by the malady that if the majority of the families received proper medical care and attention,

and if their systems were in a properly resistive state, disease and mortality would be considerably reduced. Proper medical attention in the majority of cases cannot be given at the patient's home as effectively as in the hospital; yet the carrying charges of the hospital are so great that the rates for admission and maintenance prohibit general advantage being taken of their facilities, except in extreme emergencies. The standard rates are by no means all the charges made, and it often occurs that the patient is required to pay about thirty cents on every dollar of admission charge for extras such as use of laboratory, anesthetic, operating rooms, etc., etc.

The cost of hospitals built previous to the war was so great that it has been found impossible to reduce the rates to bring their benefits within the reach of the ordinary citizen without running the institutions into excessive debt. This fact is impressed upon us by the repeated requests that are being made for public assistance or government grants. One of the newest hospitals in a prominent city of Canada went in arrears, I believe, last year over sixty thousand dollars. Another, I am given to understand, found the burden of carrying charges so great that the use of two hundred beds of its accommodation have been discontinued, in order that carrying charges might be reduced. The hospitals to which specific reference is made herein are more or less monuments of architectural excellence. Their construction is of the multiple storey type, one of them, I believe, being a modern building about nine storeys high. Wherein lies the impossibility of economically administering such buildings? Is it due to over-staffing? Is it due to an abnormal amount of service rendered to the patients housed there? You will agree, I am sure, that this is not the reason. One of the big reasons is the excessive first cost of construction. If this can be reduced to an economic amount, the problem of economic upkeep is to a large extent settled.

With the enormously increased cost of labor and materials during the war, hospitals constructed to-day will labor under more adverse circumstances as to upkeep costs than those that at present exist. I was advised about three months ago by the chairman of the biggest builders' exchange in Canada that

they considered that building costs have had a minimum increase of fifty per cent. When applied to hospital construction, where special equipment, ventilation, heating systems, etc., are required, this increase in cost will closely approximate sixty to sixty-five per cent. Taking an average of nineteen general hospitals constructed before the war, the average cost ran three thousand dollars per bed. These hospitals constructed to-day, with the increased cost of labor and materials, would cost at least five thousand dollars per bed without furnishings.

In considering a hospital and its functions, we must think of it as a living thing. Its functions and general uses are constantly changing. This must be the case, due to the rapid progress that is constantly being made in the science of medicine and surgery and the advancing methods instituted for the well-being of the public. We have at every hand examples of the rapid progress, inasmuch as hospitals constructed comparatively a few years ago are now obsolete. Does it not seem logical, therefore, that in considering the erection of a hospital, careful thought must be given to future requirements?

Cities and towns throughout the length and breadth of the country are to-day burdened with the upkeep of institutions whose original cost was so excessive that there would be an avalanche of public criticism should those in authority take the necessary steps to have them demolished. Such object lessons surely teach us that in designing a hospital we should build it so that it may be easily altered to meet the ever-advancing requirements.

Buildings of massive steel or reinforced concrete construction, of the multiple storey type, cannot possibly lend themselves to such future alteration. Neither is such type of construction in any way economic as to first cost and carrying charges.

Let us, for a moment, consider the industrial concern, whose main object coupled with first cost is reduction of overhead charges so that they may put their article on the market at the lowest possible cost. Do they construct their buildings of the multiple storey type? No. We see their industrial plants covering acres of ground, the buildings usually being of one or two-storey construction. By this method of procedure, they

at once reduce their capital expenditure, handling charges, fire risk, etc., and, at the same time, when their business grows, or methods of manufacture change, their plant may be readily altered to suit their progressive policy.

This reasoning in a large measure holds in the matter of hospital construction. In the matter of office buildings, and others that require to be in the heart of business activities, the multiple storey type of building is an absolute necessity in order that a maximum amount of floor space may be obtained on a small city lot; but I am sure that no one will contend that the building is economic when considered solely from the standpoint of construction cost. A skyscraper of ten storeys has only one floor of its structure which is economic as to construction, namely, the tenth floor. This floor supports only the roof, and at the same time gives an equal space to the first floor. The first or ground floor, besides supporting its own weight, must support the weight of nine storeys above it, and its four walls surround only the same area as the tenth floor. Reasoning as applied to office building construction may in isolated instances be applied to hospital construction, where it is found absolutely necessary to construct an institution in the heart of a city.

Such reasoning does not, however, hold in the majority of cases, and I think that it is definitely established that the ideal location for a general hospital is one that is removed from the general activities of everyday life, in a location which is naturally beautiful, lying on the outskirts of the city. Such a site will tend toward the well-being of those who will undergo treatment there. Is it not ill-advised to construct a building, on a large plot of ground, of the multiple storey type, when so much park land is available? It would be more logical, I contend, to build buildings of one or two storeys in height where the patient in recuperating from his disability may feel the immediate adjacence of the beautiful surroundings, and not have that feeling of being cooped up on the top floor of a high building similar, in many respects, to a down-town tenement. As authorities see it to-day, the hospital is a building for recuperation, and the patient should be made to feel a pleasant anticipation of what his surrounding will be, rather than feel

that he is going to an institution of a cut-and-dried business-like type, where he will continually long for the day when he is to be returned to his own home.

In review of the foregoing, we may lay down the special considerations that should govern the final adoption of any policy as to hospital construction. These may be enumerated briefly as follows:—

1. First cost.
2. Efficient administration as to medical and surgical requirements.
3. Efficient administration as to upkeep costs.
4. (a) How to make the structural type of the building coincide with its useful life.
(b) How to make the general design and construction of such an elastic nature that it may be extended from time to time at minimum cost, without disrupting the entire administration.
(c) How the institution may be changed or altered to suit the ever-changing requirements that occur, due to the advancing methods in the science of medicine and surgery.

Analyzing these considerations, I would recommend as follows:—

1. The erection of an institution of proper fireproof construction, built along such lines that the initial cost will save the taxpayer easily a third of the amount usually appropriated for such purposes. Consider an institution of, say, 500 beds. The amount of interest on debentures, together with allowance for sinking funds, etc., saved, would provide a yearly sum closely approximating one hundred thousand dollars. This amount wisely expended in improving administrative facilities as to efficient numbers of help, nurses, doctors, etc., would accrue to the direct benefit of the citizens, whereas if it was sunk into elaborate construction, which cannot be avoided in the construction of multiple storey buildings, the return would be nil.

2. As to efficient administration, with respect to medical and surgical requirements, an institution built along the lines herein contemplated would leave nothing to be desired, and Canada's war hospitals have furnished the entire proof in this connection. The relation of one department to the other with proper planning can definitely be arrived at, and the skill of the doctor aided to the largest possible extent. In Canada's war hospitals the latest decisions with respect to clinics, operating suites, X-ray departments, examining rooms, electro-, hydro-, and mechanotherapy departments, etc., etc., and their proper relation to bed accommodation have been made effective.

3. It has been contended that buildings of one or two storeys in height are costly to administer, both from the standpoint of staff and the matter of upkeep charges as to heat, light, power, etc. This is definitely not the case. On the other hand, the matter of general administration will be considerably facilitated. It can be successfully demonstrated that the general lay-out can be so arranged that each department of the hospital, with its full complement of administrative services, will be quite as self-contained as in the multiple storey type of hospital. The matter of extra cost as to heat, light or power, is a negligible factor, and the results obtained in war hospitals built in Canada have conclusively demonstrated this point. Would it not be approaching the ideal to have an institution where transference of patients from one location to another is not interrupted by the necessity of using elevators and stairways? Such a condition has many virtues which need not be further enlarged upon here.

4. The type of design which is contemplated in this report will provide for the extension of any amount which may be properly administered by one institution. In the event of extension, there will be no disrupting of administrative facilities, and while extensions are being made, those housed in the institution will not be annoyed or distracted by the continual traffic through halls and corridors by construction gangs. With the absolute certainty of advance in methods of medicine and surgery, units of the hospital from time to time may be demolished, and new units erected to meet the requirements.

This, similar to the matter of alteration, may be carried out without disrupting the entire institution.

In the foregoing considerations we have not touched upon the question of general appearance. Considering the problem from the purely aesthetic side, which is very often the only point of view from which the architect considers the problem, it is established that an institution built along the lines recommended will leave nothing to be desired. It will be in entire harmony with its surroundings, and have the necessary touch of domestic atmosphere so necessary in an institution of this kind. I venture to say that a multiple storey building could not obtain, in any such degree, these requisites. By adopting a system of multiple ward units, of one storey, or at the most, two storeys in height, every necessity can be fulfilled. Medical men admit to-day that fresh air and sunlight are wonderful aids to their professional skill. They are constantly increasing this form of treatment. The multiple ward unit construction aids the doctor in this matter as no other system of hospital construction could. In order to obtain abundance of fresh air and maximum sunlight, together with beautiful views of the immediate surroundings, the multiple ward unit is the only scheme that will give the maximum desired results.

It may appear to some that the considerations set forth herein are the personal observations of the writer. This is hardly the case. New ideas as to economic hospital construction have been gaining headway both on this continent and in Europe. Dr. Donald J. MacIntosh, M.V.O., M.B., LL.D., F.R.S.E., Medical Superintendent of the Western Infirmary, Glasgow, and Assistant Director of Medical Services, Lowland Divisional Area, in the second edition of his book entitled "Construction, Equipment and Management of a General Hospital," published in 1916, states in part as follows:—

"The problem that confronts an architect in dealing with this type of hospital is how to make the structural life of the building coincide with its useful life. The rapid change of medical opinion as to the methods of treating

disease affects the internal arrangements to a considerable extent. Also the standards of sanitation, heating, lighting, and ventilation, etc., constantly tend to rise. The result is that comparatively modern buildings have fallen out of date though still quite good structurally. - In view of these facts, an architect is now required to design a hospital at a minimum of expenditure. As long as he can construct a building that will be weatherproof and comfortable, and can be maintained at a moderate cost during the length of its useful life, he is entitled to reduce the initial cost even at the loss of durability."

When an authority like Dr. MacIntosh takes this view of hospital construction, a man who has been an accepted authority during his entire professional career as to hospital construction, his recommendations must have some weight.

Dr. Joseph Griffiths, C.M.G., M.D., Mag. Chir., F.R.C.S., in his pamphlet entitled "Hospitals, Yesterday, To-day and To-morrow," follows the same reasoning as that advanced by Dr. MacIntosh.

Dr. Griffiths goes even to the extent of saying that the most temporary type of construction can be made to provide the best of facilities for treatment purposes, and recommends the adoption of this type of construction.

In discussing the subject and making some reference to a hospital, the design of which he was instrumental in promoting, Dr. Griffiths states:—

"The main object of a hospital, namely, the provision of conditions, surroundings, and facilities for rapid cure of injured and diseased men, was always kept steadily in view, but money was not spent on unnecessary bricks and mortar, which can in no way whatsoever add to the value of an institution for the restoration to health of the sick and the wounded."

In another portion of his pamphlet he states:—

"The provision of a sufficient number of general hospitals for the people has been uppermost in my mind. Hither-

to, the difficulty encountered has been the erection of a hospital that will serve all purposes, but at a cost that can be met with comparative ease by the people of the locality. Our money is required to pay for skilled labor, whether in the kitchen, in the office, in the wards, or elsewhere, and this we can have, I feel convinced, if those to whom we look for it can first be convinced that the means of cure do not lie in costly buildings. The buildings must, of course, be commodious. They must be arranged to economize labor; they should be well lighted and well ventilated and sufficiently weatherproof to protect the patients from the inclemency of our very changeable climate."

A friend of mine, knowing my interest in the future development of hospitals, has forwarded to me a copy of the Cavendish Lecture delivered before the West London Medical Chirurgical Society on July 4, 1918. The lecturer at this society was Sir Bertrand Dawson, G.C.V.O., C.B., M.D., F.R.C.P., Army Medical Service, Physician-in-Ordinary to H.M. the King, Physician to the London Hospital. As is well known, the meetings of this society are considered of the greatest moment in medical and surgical matters. Sir Bertrand Dawson in the course of his lecture makes specific reference to the urgent necessity of providing ample hospital accommodation for the public, and in order to illustrate his recommendations he says:—

"In this connection let me call attention to a valuable pamphlet, 'Hospitals, Yesterday, To-day and Forever,' by Colonel Joseph Griffiths, of Cambridge."

Sir Bertrand Dawson makes a slight error in the title of Dr. Griffiths' pamphlet, but his entire concurrence in Dr. Griffiths' views is evidenced by his reference to this very able work.

We may refer also to one of our Canadian medical experts, namely, H. E. Young, B.A., M.D., C.M., LL.D., Chief Officer of Health, British Columbia, and President of the Canadian Public Health Association. Dr. Young read a paper before the first annual Convention of the Hospitals of British Columbia, and an abstract of his paper appears in that eminent publi-

cation "The Modern Hospital." This abstract reads in part as follows:—

"It is said that in medicine the best service can only be obtained by millionaires or by the very poor in the cities. The millionaires get it by paying for the services of experts. The very poor get it gratis in the hospitals of our cities which are manned by these same specialists but the great mass of the people are not able to avail themselves of these privileges. At the same time, it is the great mass of the people who, through their taxes, are keeping up our institutions and are paying the cost, and it is beginning to dawn upon every one that they are entitled to an equal service with their fellow-citizens of any class. The idea has germinated that will result in a movement toward establishing hospitals that will be at the service of every one."

The present paper deals only in a general way with the matter of the hospital from the public standpoint. No special endeavour has been made to consider the exact procedure that should be followed, as the solution of the problem is one having many phases too lengthy to be discussed at detail in one article. The discussion, however, appears to lead us to the fact that those who were designers of hospitals in pre-war days, were more or less idealists and unconsciously seemed to feel that the hospital should necessarily be a monumental structure, composed of indestructible materials that would ensure its existence for all time to come. Quite true, any institution for the use of the public at large should be of such a type as will create pride in the hearts of the citizens in the community where it is located. When, however, the method followed to obtain such monumental excellence leads to undue expenditure as to first costs, and at the same time does not in any way further the interests of the patients, we cannot but conclude that such practice is impracticable and uneconomical.

CANADIAN HOSPITAL CONSTRUCTION

MR. G. W. ALLSOP, Fellow of the Royal Institute of British Architects, and Architect to the Auckland Hospital Board in New Zealand, has been inspecting hospitals for the past several months, travelling far—having been in the north of Scotland and Ireland, the battle-fields of France, to Venice, Rome—and incidentally to Monte Carlo (where he nearly lost money.) He says the British hospitals were disappointing—the Canadian ones, on the whole, being superior.

Writing to one of our editorial staff, Mr. Allsop says:—

Having completed my trip through Canada, England, Ireland, Scotland, France, Switzerland and Italy, I am now in New York and working across the States to Frisco and by boat from there home to Auckland, New Zealand.

My object is to inspect modern hospitals and note their general design, the materials used for internal finishings, the design of sanitary fittings and how installed, the cooking fittings and the multiplicity of other matters common to all hospitals.

Having spent five years in London studying hospital design, and obtained my degrees by taking this as a special subject, being architect to four Hospital Boards, and having devoted practically the whole of my time to hospital work during the last fifteen years, I think I can claim to be qualified to express an opinion upon what I have seen.

In New Zealand, we have a beautiful climate and we give great attention to flooding our wards with fresh air and sunlight; we also give great attention to cross ventilation of wards and sanitary towers. Our medical authorities are great believers in the curative properties of daylight, sunlight and fresh air.

In the Canadian institutions that I saw (about twenty), I noted a great absence of all these points. No doubt your severe climate influences your cross ventilation, but your wards impressed me as being dull and cheerless. I noticed the area of window space was considerably less than the area of wall space. There is no reason why this should not be reversed (as in our hospital); then your patients would have the benefit of the

curative properties of more daylight, sunlight, and in the mild weather of more fresh air.

All windows should have fan-lights over two feet deep, hinged at top, swinging outwards. Most of your windows have no fan-lights; the few that had I never saw one open. Again I noted a considerable space between the tops of windows and ceiling; this means a pocket for stagnant air. Obviously this space is of no advantage to the patients and adds considerably to the cost of the buildings. We always carry our fan-lights to within three inches of the ceiling.

Our authorities allow twelve hundred cubic feet per bed, and will not allow any measurement of height above the top of fan-light for the reason I have stated. When fan-lights are hinged at the bottom and fall inwards, the air, carrying a certain amount of dust, is turned up to the ceiling, which gradually discolors same; it also causes down-draughts on the patients. This is obviated by putting checks at the sides, then a pocket is formed, and I have seen dust over one inch thick lying at the bottom. Now, obviously, when a strong wind or gust blows, this dust is carried into the wards. But when the fan-light is hung at the top it swings out and forms a hood over the opening, preventing the rain from beating in; the air is not deflected on to the ceiling or patients, and no dust accumulates.

I have installed hundreds of these and many of them stand open all the year around, except when wards are being fumigated. Again, we place every bed between a pair of windows in all wards, whether of one or more beds. This gives more light and air to each patient. I note you do not study this point.

Many of your hospitals have chutes for soiled linen and some for rubbish. With but one exception they all had small doors opening into the corridors or passages. The advisability of this installation is, in my opinion, doubtful. When chutes do not exist the custom is to place the soiled linen in bags and these are taken away by the porter. If the chute exists, the soiled clothes are carried to and dropped down the chute. It is admitted (and can be seen) that the chutes become soiled; as the air inside the building is warmer than outside, these chutes become inlet ventilation shafts every time a door is opened, or

when doors are carelessly left open (I saw several instances of this;) consequently, air ascending this fouled chute is discharged inside the building.

The fact of a cold shower being fitted at the top of the chute is no guarantee that the blood, etc., will be all dissolved and the walls thoroughly cleansed. I did not find them so.

It is not advisable to study the saving of a small amount of work of the nurse or porter to the detriment of the health of the inmates. If the chute be omitted and a small room provided near lift for soiled linen, it should meet all requirements, and would cost considerably less. In the Ross Pavilion, at the Royal Victoria Hospital, Montreal, I was informed these chutes were omitted intentionally, and in my opinion this is the best designed hospital building in your Dominion.

Whilst all your hospitals have large numbers of radiators (steam or water) I did not see a single instance of a modern hospital radiator in use. The radiators consisted of two or more columns in a section, the sections were (in most cases) close together, no space being provided for cleaning; the radiators were fixed to the floor and close to the wall so that it was very difficult to clean under or at the back.

The proper hospital radiator has one column in a section, each section spaced wide apart for ease of cleaning, and the radiator fixed nine inches up from the floor to a bracket screwed to the wall. The radiator swings on this bracket like a gate, and can be pulled out from the wall at right angles so that the cleaning of the floor, wall and back of radiator is a matter of simplicity. These gate radiators have been in use for many years; they are made by Beeston's and other firms, in England. I have installed many of them years ago, also recently, and they are quite satisfactory.

Radiators are not ideal fittings to install in operating rooms, owing to the many recesses forming lodgement for dust and germs. This can be overcome, to a great extent, by slipping over the radiator white linen covers; these can be washed frequently, they look nice and serve a useful purpose. In three hospitals only in Canada did I see them in use; they could, with advantage, be installed in all.

In the sanitary fittings, such as bed-pan sinks, W. C. sinks, and lavatory basins, I was disappointed. All the fittings I saw were similar to those used in domestic buildings; special fittings for years past have been designed, catalogued and installed in hundreds of British hospitals. Such firms as Doultons, Shanks, etc., of England, issue special hospital catalogues, showing and explaining these fittings in detail. They willingly send them for the asking.

All of these specially designed fittings are supported on brackets, built into the wall. No portion of the fitting rests upon the floor; they have no legs, consequently it is a simple matter to clean the floor under and around these fittings.

In no hospital did I see a urine bottle washer attached to the bed-pan sink. This is a most useful fitting; it cleans the bottle thoroughly and quickly and prevents the nurses having to do this in the old-fashioned way. In some hospitals there was no rising jet fitted to their bed-pan sinks; this was obviously an error in selecting the fitting, but many hospitals had them.

In one large hospital I visited in Canada they had the most remarkable fitting for a bed-pan sink I have yet seen. On the floor was fixed a cast iron trap and from this arose a cone four inches wide at the bottom and about twenty-four inches wide at top; from the floor to the top the height would be about thirty inches. Over the cone and about two feet above it, was a tap with a piece of rubber hose attached.

The cone was made of copper, was polished inside and out, and the appearance was very nice. But a more unsuitable, out-of-date, and obsolete fitting I have never seen installed, and hope I never shall. There was no flushing rim, no rising jet for washing bed-pans, and no bottle washer. The nurse had to empty the contents of the pan into the cone, then hold the pan in one hand whilst she played the hose upon it with the other, then the nurse had to lean over the cone whilst she directs the short length of hose upon the excreta, clinging to the sides and floating in the bottom, and finally someone has to lean over whilst they go through the tedious process of polishing this large surface of copper inside and out.

Why the medical and health authorities allowed this fitting

to be installed in a new building is beyond my conception. They are installed in operating rooms and all sanitary rooms; there are a large number of them in the building, and in all fairness to the nurses and patients, these fittings should be taken out and replaced with modern fireclay sinks with all fittings as I have previously described.

It will be obvious from this that a building may be of recent erection but not modern.

Tiled dadoes and tiled walls were not used nearly to the extent they should have been; the few I saw were mostly placed on top of the plaster, leaving a ledge at the top. The face of the tile should be flush with the face of the plaster. All walls, including corridors, should have tiled dadoes at least 4 ft. 6 in. high. They are easily cleaned, very durable, prevent the cutting away of plaster by moving articles, such as tables, trolleys, etc., and obviate the constant cleaning, scrubbing and re-painting which is otherwise necessary. This repairing comes under the heading of maintenance, which is the nightmare of the officials responsible for that department.

My object in writing in this strain is not one of fault-finding, but in the hope that by calling attention to these items they may receive attention when the new buildings are being erected.

Selected Article

THE LADY WITH THE LAMP

Torch after torch has been lighted by hospitals and hospital nurses from the flame that the Lady of the Lamp held aloft over fifty years ago. On this her centennial day Toronto's nurses are asking for more torch holders.

Of all the tributes to the noble work of Florence Nightingale few are more moving than these words from the story of Florence Nightingale, of Hodder and Stoughton:

(The Crimean Veteran, lying ill in a London hospital, tells how, many years ago, the Lady lit the Lamp.)

Is that lamp going out? The light looks very low. Surely the oil hasn't given out?

That little night-lamp flickering away there on the hospital wall is the only thing between me and the utter dark.

Fancy an old man like me, a Crimean veteran, being afraid of the dark.

Well, I am afraid—I am afraid of the terror by night. I dread the night as much as any tiny frightened child.

Do you think the dark can ever bring anything but horror to an old soldier who spent a night on the blood-drowned slopes of the Alma, a night in a jolting litter, nights in a hospital ship, nights, nights, nights at Scutari?

It will be very wonderful to see the pearly gates and the golden streets, but I shall know I've really reached heaven when I try to remember the distant days that have passed—and cannot.

That's why I am so glad to know that it's always light in heaven, that there's no night there. Here in the night I try to forget—and cannot.

I can forget in the daytime in this clean and comfortable ward where everyone seems anxious to ease the last days of an old soldier who has fought for more than half a century, and has been wounded in many battles, wounded at Alma, wounded often and sorely in the daily skirmishes in the streets of the city, in the long pitched battle with age and want and care.

For I have been wounded in the house of friends and on the field of the foe, and peace has been for me a fiercer fight than war.

But every night as the darkness settles over the row of neat white-covered beds, I go right back over the long years and feel beneath me that other bed, that unclean thing in that dreadful hospital by the Bosphorus, and every night as I lie tossing in that unforgotten agony which the years have not lessened by a single pang, I watch that light over there and wait and wait till I see my Lady with the Lamp coming. It's only my fancy, of course, but somehow it seems to me, as I lie here, that still.

as in those Crimean days, she comes every night and holds it over my head.

Then at last I can fall asleep and forget, for I know that when she is near all will be well and that she will see that the lamp is trimmed and filled with oil. I know she will never leave me in the dark.

But to-night she has not come and the lamp looks so low. Surely it can't be going out.

That light, there, is just like the lamp she carried. How we waited for its appearance every night in that fearful blackness, how we watched it as it came slowly down that way of sorrow between the long lines of the wounded. Now and again it would stand still, and we caught sight of that sweet, slim black figure with the white cap, bending over something that was once a man.

Then it would move on again, and as it passed groans were hushed, mutterings were still, and men who could not move except in agony turned on their pillows to kiss her shadow on the bed.

Every night I lay with my eyes straining towards the first glimmer at the door, and I would sweat drops of anguish as a puff of wind caught the tiny flame and almost blew it out.

If that lamp had gone out before it reached me I should have died. It was the light of our life.

For in the dreadful darkness, so crammed with all that was terrible in death, and more terrible, so much more terrible, in life, that light was the one thing in a whole world of misery that told us we were not altogether cast away by God and man. It was the one thing on earth that spoke of love and pity and kindness to men who had lived for weeks on hate.

For weeks we had eaten and drunk hate, rolling horrid thoughts of revenge in our mouths.

One day before she came a soldier in the next bed called out: "They must hang someone for this," and I can feel now how, when we heard him, our eyes glistened and our faces flushed as we repeated to ourselves: "Whom will they hang? Someone will swing for this."

Surely we did well to be angry.

We had fought like men, and they had left us to die like dogs.

We had won a glorious victory and this was our reward.

We had looked unflinching into the jaws of the Russian artillery, with their flaming tongues and blackened teeth, as we lay on our faces on the slopes of the Alma; we had not wavered as the shrieking shells ripped their way into our midst. In all that two-mile line of red there was not a man who murmured as we dressed our ranks to fill the places of the dead.

We never halted in the vineyards by the river as we stumbled blindly through the storm of shot and shell—

“Forward, the first company!”—We did not shrink as we came within the range of the guns of the great redoubt, when canister and grape and rifle and musket balls swept us in blasts from every side—I can hear them shouting madly as the color gained the breastwork—and we had no feeling but pride in a day’s work well done as we fell at last—gasping, broken, shattered, on the hill side.

We uttered no complaint through the night as we lay where we fell among the dead and those who had been so much better dead. We knew the price we might have to pay. And we paid it.

We paid it as they carried us those four unending miles to the ship, every step a mile of torture, and as we neared Scutari and saw the brightness of the hills we thought in our folly we had paid in full.

Paid in full?

We did not begin to pay till we reached the place they had misnamed a Hospital, where at last, as we thought, we might rest or at least die in peace.

When I remember the sights of Scutari, the dripping slopes of the Alma seem like a garden of roses; when I think of the sounds of Scutari the whizz of bullets and the crackling of shells seem like sweet music; when I call to mind the smells of Scutari the reek of powder seems beautiful perfume.

They left us to rot and die in Scutari, our festering wounds undressed, our mangled bodies unclothed.

Beasts die no such death as my friends died there. Beasts live no such life as I lived there.

That's how my Lady of the Lamp found us. That is what we were like when she came to us with her little lamp in her hand.

To us she was just the Love of God, and her lamp the pity of man. When we saw her face, heard her voice, felt her touch, we knew that there was a God and that she must have come straight from Him to Scutari.

And we knew, too, that the lamp she carried had been filled with oil by those at home, knew that they had not altogether forgotten and forsaken us.

Through all these years, when life has been almost too hard to bear, when God seemed hidden and men without pity, I have watched for and waited for my Lady of the Lamp.

And she has always come, and I have always known that I was wrong, that God does not forget the wounded soldiers, and that while men may, and do sometimes forget, He always reminds them.

And when they remember, men are very kind.

I'm not proud of being a Crimean veteran—it was easy to be brave in those hours of splendid frenzy—but I am proud that after fifty years of battle, fifty years, mind you, not one glorious day at Alma, I owe no man anything, I've clean hands in a dirty world. My uniform is stained and ragged, but I've kept my honor untarnished, and I've never turned my back on the enemy.

For the peace and comfort and ease of pain that have come to me now—old, crippled, marred, scarred in the long years of battle—I thank my Lady of the Lamp who taught men to care for the wounded in war.

She has not come to me to-night.

But the lamp is there.

Surely it is not going out? Surely she will not leave me in the dark?

The Hospital Nurse takes up the story and tells how the work of the Lady with the Lamp still goes on.

If only the people cared now as they did then.

To-day we turn away men and women—and little children who have been wounded before the fight has fairly begun.

We could not take them, we had no room.

We are doing all we can but there is so much more we might do if only . . .

For a little time the veteran lay with his eyes straining towards the other end of the ward as if he expected someone to come in at the door. Then suddenly he started up, threw the clothes from him, and tried to rise. Do you see, Nurse? he said; that lamp is going out. And all for want of a little oil.

As I looked the night-light flickered and sank.

Her lamp must not go out, he said sharply. But what can I do? My Lady of the Lamp is not coming to-night. It may be the General has greater need of her somewhere else, or is she, at last, taking her rest?

Do you think I can sleep here when so many wounded are waiting for my bed?

It's so little I can do to help my Lady of the Lamp, but if I went out, Nurse—out into the dark, if my bed were empty you might perhaps save one, just one, wounded soldier.

It's all I can do. If I were rich, if I were strong . . .

I tried to soothe him, but he shook me off and tried to rise from his bed. "You shan't stop me," he cried. "I'm going—now. Look, her lamp is going out. Let me go at once. Now."

I looked at the light. It was almost out.

I turned back to the bed. The veteran had passed to where they need evermore no light of lamp.

But the little night light on the wall flamed up brightly again.

It was as if someone had just trimmed it, had filled it with oil.

And a shadow fell across the bed and softly smoothed the lines of battle on his face.

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ONE of the most objectionable things in any institution is the presence in the pantries and kitchens of cockroaches and beetles, or in the wards and servants' quarters, fleas and bugs. Few hospitals are free of these pests, so that medical superintendents and superintendents of nurses welcome any preparation that will get rid of such live stock. Keating's Powder has proved itself to be a successful exterminator of all such and, where it has not been tried, should be promptly ordered, as once used it will not be substituted.

Allenburys' Milk Food

The high death rate of young infants each year is well known, and it is recognized by the medical profession that infected milk is the chief cause; indeed, this is not to be wondered at, when one considers the many dangers to which cow's milk is exposed; for instance, there is the cow, she may be tuberculous or suffering from some form of mastitis. There may be infection from the milker, or again, the receptacle used, all affording many opportunities for the milk to become infected from the time it leaves the cow until it reaches the infant's mouth. While it is gratifying to see that greater care is being taken each year to overcome these dangers, yet it is still almost impossible in crowded cities with a milk supply obtained from a distance, to overcome them, and many physicians frequently find it necessary to adopt some other method of infant feeding.

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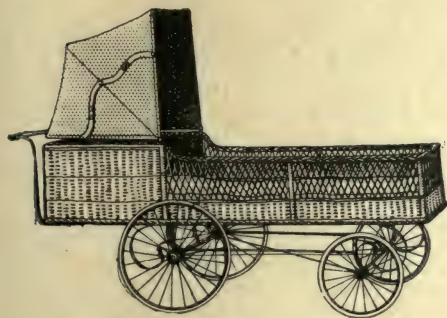
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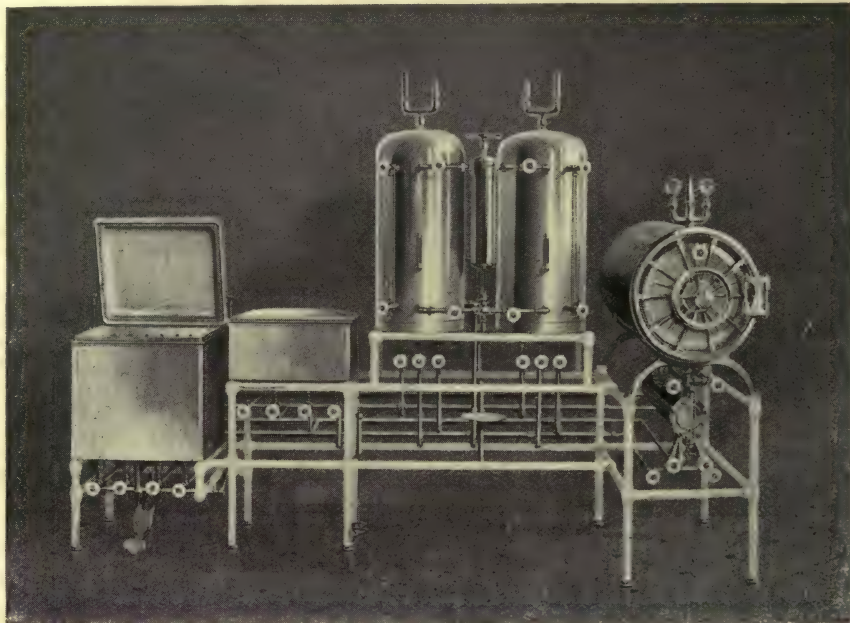
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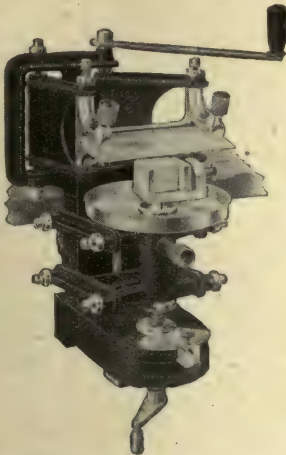
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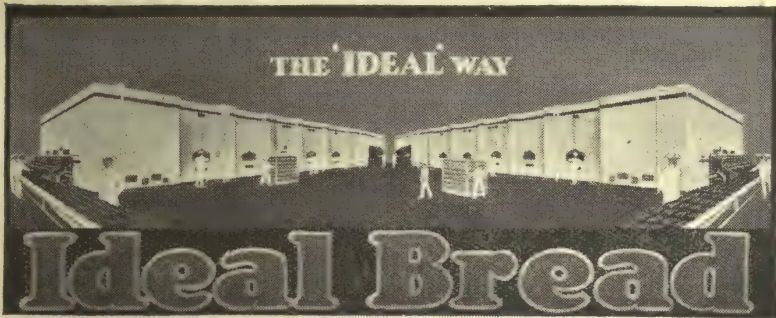
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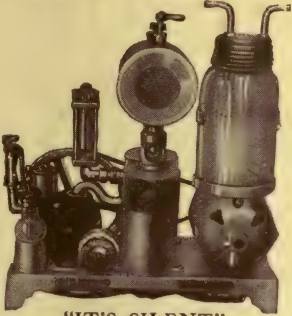




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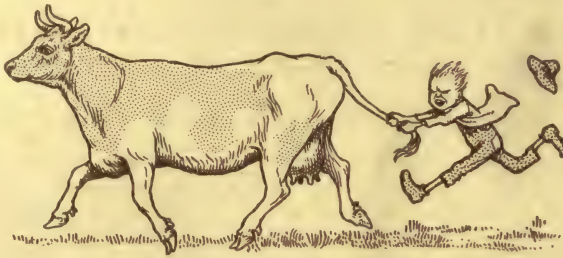
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THE HOSPITAL WORLD

Vol. XIX

Toronto, May, 1921

No. 5

CONTENTS

EDITORIALS

	Page
The District Hospital and Medical Health Centre	139
Hospitals for Insane in China	143
Are Hospitals Safe from Fire?	145

ORIGINAL CONTRIBUTION

The Arctic Hospital. By Hudson Stuck, D.D., F.R.G.S.	148
---	-----

HOSPITAL ITEMS

	Page
Hospital's Big Deficit	158
Consider Nurses' Home	159
Fire at Orchard House	160
New Nurses' Home Opened at Kitchener	162
Nurses' Training School at Brussels to be Memorial to Edith Cavell	163
Graduate Nurses' Association	163
New Nurses' Home, City Hospital, Hamilton	166
Reception Hospital to be Built at Once	167

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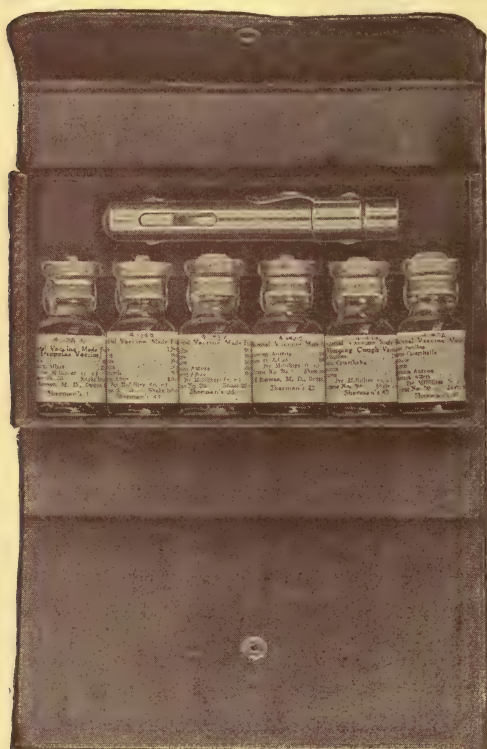
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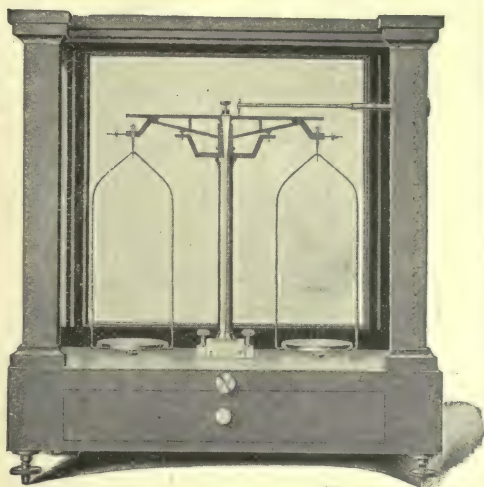
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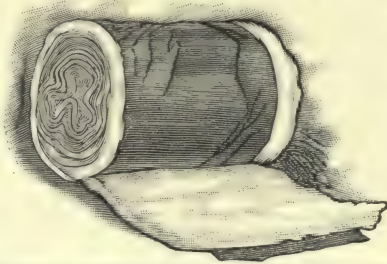
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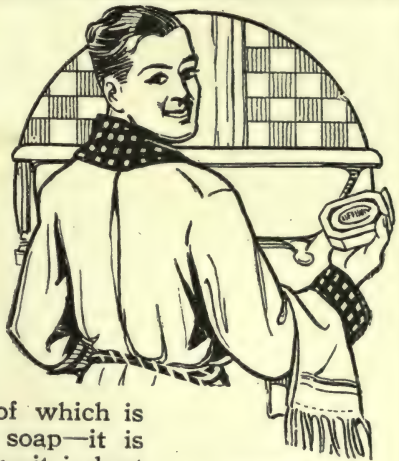
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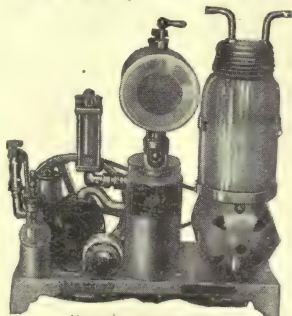
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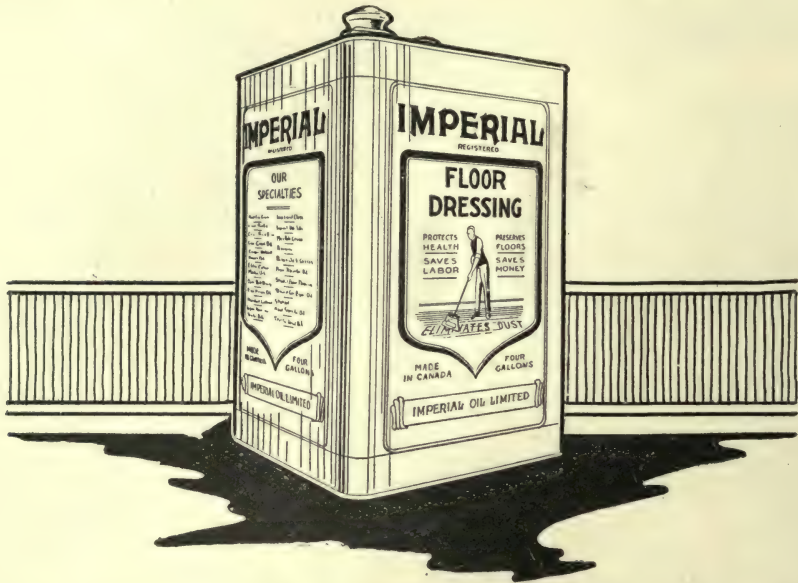
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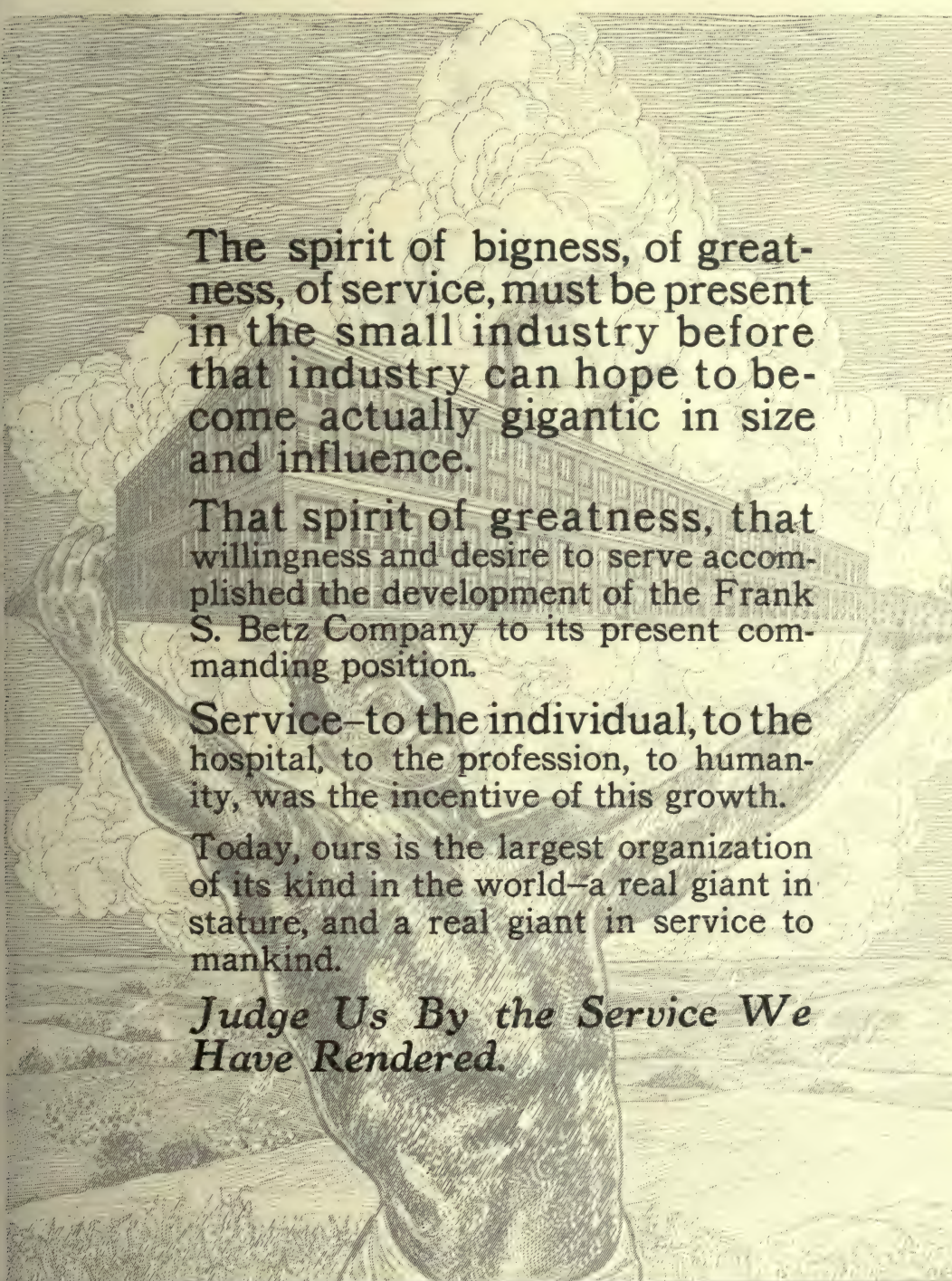
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The Hospital World

TORONTO, CANADA

**A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire**

Vol. XIX.

TORONTO, MAY, 1921

No. 5

Editorials

THE DISTRICT HOSPITAL AND MEDICAL HEALTH CENTRE

THE District Hospital and Medical Health Centre now has the centre of the stage. Throughout the United States (and we hope Canada will follow, or better, lead) there is a movement on foot to provide hospitals for every district—one, two or more municipalities. Saskatchewan has already such a plan legislated for (in so far as the hospital end of the project is concerned), and has some forty or fifty hospitals already running, and as many more under way.

In the United States it is proposed to have a medical and surgical building with an obstetric department; a contagious building, and a tubercular building. Of course there must be laboratory and X-ray facilities. An internist will be responsible for all work done on the medical side and a surgical

chief for that of the surgical. Any reputable physician may bring his confinement case in and look after it.

It is contemplated that there shall be a nursing staff. One of the prominent men who endorses the scheme suggests that all nurses be graduates. As to having a training school, the number of patients to be accommodated—whether sufficient to allow of a practical training to the nurses—would decide that point.

As a health centre an additional building would probably be required. In it the activities of visiting nurses, baby welfare, venereal workers and the like could be carried on. In the United States there is talk of connecting up with the State Department of Education.

The Health Centres Bill in New York State, according to Dr. E. L. Hunt, in the *New York State Journal of Medicine*, stipulates that—

The Board of Supervisors of any county could establish a health centre, which would serve the whole or part of the county. The plan was optional. The details were as follows: The erection of hospitals, the formation of clinics for out-patients, clinical, bacteriological, X-ray and chemical laboratories; the establishment of public health nursing service, and headquarters for all other public health, medical, nursing, and welfare agencies of the district; co-operation with the State Department of Education in securing proper medical supervision and medical inspection for school children; periodical medical examination of such inhabitants of the district as desired it.

The location, site, plans, and initial fixed equipment of the centre would be subject to the approval of the State Com-

missioner of Health. The Board of Supervisors, when they had decided to establish such a health district, would have certain powers which would be to purchase or lease real property, to enter into contracts, to cause to be assessed, levied, and collected such sums as they might deem necessary, to accept and hold in trust for the county any grant or devise of land, and to appoint a Board of Managers of the Health Centre, which should consist of eight members, including the Commissioner, the President of the Board of Health, and of the other members at least one woman and two duly licensed physicians.

Their powers would be: to appoint a Superintendent, to fix the salaries of the Superintendent, to exercise general management and control of the said health centre, grounds, buildings, offices, attendants, physicians, employees and inmates thereof; to make such rules and regulations as advised by the Medical Board as being necessary for the study of the nature and cause of death in cases terminating fatally; to make rules and regulations regulating the fees to be charged for all medical and surgical services, to fix the salaries of attending physicians, and to make rules and regulations for the carrying into effect the purposes of such health centres; to erect all additional buildings; to employ within the limits of its appropriation public health nurses; to appoint a Medical Board; and to appoint and employ, after consultation with the Medical Board, all members of the medical, surgical and laboratory staff of the Health Centre.

The Superintendent of the Health Centre would be the executive officer subject to the Board of Managers, and to the approval of the State Commissioner of Health. His duties would be to equip the Health Centre, to have general supervision, to appoint any other employees, to cause proper accounts to be kept, to receive, subject to the rules and regulations, into the Health Centre, any person in the health district who might be in need of medical or surgical care, irrespective of whether such person could pay for the care. He would also cause to be made such inquiry as he might deem necessary as to the ability of each patient to pay for his care and treatment.

The bill stated that any physician attending any patient prior to such patient's admission to the hospital or the Health Centre should be allowed, if the patient so desired, to continue such treatment while the patient remained in the hospital.

In the cities the bill provided that the Mayor appoint the members of the Board of Managers of such Health Centre, and that the Board of Health of such city, if there should be one, should be appointed as now or hereafter provided by law.

The State, through the Legislature, should provide the following aid: For the construction and equipment of hospitals, one-half of the cost thereof; a grant of seventy-five cents per day for each free patient maintained in any hospital operated as a part of such Health Centre; a grant for the establishment of each out-patient clinic; a grant towards the ordinary current expenditures for free treatment; a grant of one-half of the actual cost of maintenance of the laboratory or laboratories of health centres not in excess of \$3,000 per annum for each laboratory, and of \$1,500 toward the initial installation.

The work of all health centres, including the hospitals, clinics, laboratories and so forth, should be inspected and standardized by the State Department of Health, and all the state grants herein provided for should be paid only on the written approval of the State Commissioner of Health, after inspection of such centre. Provision should be made by the State Commissioner of Health for occasional or periodical consultations and clinics at the health centres by specialists in medicine and surgery.

Persons able to pay in whole or in part for such services would be charged a reasonable sum therefor, and the sum so received would be paid into the treasury of the Health Centre. It was not intended that this arrangement should in any way affect the private relation which might exist between the patient and his own physician who might bring him to the Health Centre.

This is as short a summary of the Health Centre Bill of 1920 as I can make in eight minutes. This measure is dead and not now before the Legislature. We have been given to understand, however, that a measure similar in principle but

differing in detail will probably be presented to the Legislature at the coming session.

There are many arguments in favor of this measure, and there are many arguments against it. It seems to me that there are three big questions which at once present themselves and which ought to be decided by you: (1) Will this legislation affect the community favorably or adversely? (2) Will this legislation affect the medical profession favorably or adversely? (3) Assuming that the two conflict, what is your duty as a medical man?

HOSPITALS FOR INSANE IN CHINA

A NATION-WIDE search for a man who is greatly needed, but who may not exist, is announced by the Presbyterian Board of Foreign Missions, 156 Fifth Avenue, New York City. "We must have him," and "There isn't any such man," representatives say, almost in the same breath. Wanted—A Doctor! That seems simple, but the Foreign Board's specifications have so narrowed the field that up to date not a solitary candidate has been found. The doctor must be under 35. He must have a knowledge of psychiatry, or be willing to learn at once the rudiments of that science of mental diseases. Such a man is greatly needed in the medical missionary work of the Presbyterian Church for a special task in China.

Twenty-three years ago, for the first time in the long history of China, a hospital for insane was opened in that land by John G. Kerr, M.D., LL.D., in Canton, where many years earlier foreign medical

work had had its very beginning. More than 40 years of his life had already been spent by Dr. Kerr in the ministry of healing as a medical missionary connected with the Presbyterian Church, North. Being 73 years of age when he took up this new work he was obliged after three years to lay it down. But this time was long enough to see the enterprise which he had long wished to inaugurate a growing institution. Its reason for existence was to extend an asylum and treatment to Chinese insane, and to give to the recovered patients and their visiting friends as well as to the helpers and neighbors, by word and by life, an opportunity to hear and see the Christian gospel of salvation and service. The hospital has now a population of more than 100, and it would have been much larger had land and buildings been available for all for whom admission has been sought.

With the exception of Mrs. Kerr, in charge of the evangelistic work, and two American physicians, the staff and helpers are all Chinese. Another American physician is needed. Few are offering their services for foreign mission work and few have made psychiatry or mental diseases their specialty. Thus far, no man with all the proper qualifications has been found to answer the call. The Presbyterian Board asks, is there not some physician in Canada with a desire to help give the gospel to the people of China, a physician having a knowledge of psychiatry, and who is not above 35 years of age. who will volunteer for this service? If this call

reaches some Christian physician even without a knowledge of psychiatry, but willing to spend a year or two in special preparation for practice among the insane, the Presbyterian Board will be glad to get in touch with him. It is not at all necessary that he be a Presbyterian.

ARE HOSPITALS SAFE FROM FIRE?

Are Hospitals Really Safe From Fire?—Many people indeed will tell us that there is no danger of fire in the modern hospital. An indisputable answer to this question is the fact that in 1920 there was a loss of \$215,753 from fire in the hospitals of Ontario. We sometimes fail to appreciate the seriousness of the situation, simply because good fortune has shielded us from the intimate touch of the fire scourge.

Should Hospitals be Absolutely Safe from Fire?—Every thinking person will find an answer in the undeniable silent appeal of thousands of helpless patients, including aged and children, whose lives cannot be measured in money and who require the greatest security from alarm or panic in their fight for a renewal of life.

Is the fire equipment adequate, and is it inspected and tested at regular intervals by a responsible person? Have you a well trained organized department to operate the equipment if the necessity arises? Remember that the equipment in such an in-

stitution should be of the very highest possible standard, and also bear in mind that unless you have an organized fire department under a capable, responsible head, your equipment will probably prove of little use in the excitement of the critical hour. To assist the fire-fighters by preventing the spread of fire, particular attention should be paid to the construction of the building. By means of fire walls and fire doors, vertical divisions should be made to avoid the horizontal spread of fire and to permit of the rapid and convenient removal of patients to safety on the same floor. Stairways, elevator shafts, linen chutes, and dumb waiters should be enclosed in fire-proof walls and provided with automatic closing fire doors to prevent fire from travelling from floor to floor. Such a construction would limit the spread of smoke and so prevent fear and panic among the patients. Could you carry patients down your fire escapes, even when not threatened by fire? Enclosed fire-proof stairways should be provided of suitable construction and dimensions for the removal of patients on stretchers if such a step became necessary.

Above all, Prevent Fire.—Avoid all accumulation of waste paper, packing material and other refuse. System and Order mean Safety.

The Hospital World

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Original Contribution

THE ARCTIC HOSPITAL*

By HUDSON STUCK, D.D., F.R.G.S.

Archdeacon of the Yukon; Author of "Voyages on the Yukon,"
"Ten Thousand Miles with a Dog-Sled," etc.

I WISH very heartily that I were not at liberty to use the title set at the head of this paper; that I were compelled to say "An Arctic Hospital" instead of "The Arctic Hospital"; but so far as I know (and I think I know all the way) there is not on the American continent north of the arctic circle any institution for the care of the sick save St. Stephen's Hospital at Fort Yukon. So far as America is concerned it is "The Arctic Hospital."

There is an unfinished building at the village of Kotzebue, on the sound of that name, intended for a hospital, but no physician and no nurse. There is a physician at Point Barrow, the most northerly point of Alaska, 500 miles north of Kotzebue, but he has no place in which to take care of his sick and no nurse. I went his rounds with him one day last winter and saw a number of patients who should have been in a hospital, and I am glad to learn that there is a probability that this sore need will be supplied next summer by the Presbyterian Church, which maintains the mission and the physician there. There is, I am told, sometimes a physician at the Northwest Mounted Police post at Herschel Island, on the Canadian arctic coast, 400 or 500 miles to the east of Point Barrow, but there was none last winter, nor had been since the war began, and there is no building on the island for the care of the sick.

To-day St. Stephen's Hospital at Fort Yukon is the only place where medical and nursing care may be had in all the "arctic sixth" of North America.

The Yukon River, pursuing a remarkable course through the very midst of the great peninsula of Alaska, reaches its most northerly point at Fort Yukon, a mile or two within the

*Courtesy of "Scribner's," New York.

arctic circle, and immediately thereafter makes the great bend by which its hitherto main northwesterly direction is changed to a main southwesterly direction for the 1,200 miles it has yet to flow to Bering Sea. At this point it receives, from the northeast, its important tributary, the Porcupine, with 500 miles of navigable length, and a little lower down the Chandalar comes in from the northwest. Many other streams, each with its complement of native inhabitants, join with the Yukon or with one of these large tributaries in this neighborhood, so that Fort Yukon has long been a centre for mission and for trading purposes, and may be described as the native metropolis of these parts—of the great central basin of the interior known as the "Yukon Flats."

On the Yukon River itself, 350 miles up-stream from Fort Yukon, is Dawson, the capital of the Yukon Territory, with a hospital; and 350 miles down-stream is Fort Gibbon, with its post surgeon and hospital; but the former is in Canada and will not receive Alaskan Indians, and the latter is a military hospital and will not receive Indians at all.

St. Stephen's Hospital is primarily a part of a plan to provide medical care for the natives of interior Alaska, long neglected in this respect by the Government of the United States, and owes its establishment to the efforts of Bishop Rowe and his clergy, and its support to the missionary society of the Episcopal Church.

Ever since the Territory came under American rule the medical needs of the natives have been urged upon the Government. The reports of the earliest governors of Alaska beg for prompt consideration of the matter; the report of the last governor returns energetically to the charge. Says Governor Strong (Report of 1917): "Without medical relief all other plans for the natives are necessarily futile. While the service now rendered in the few places mentioned is efficient and valuable, the total results are meagre when compared with the total native population."

The recent reading of a long file of governors' reports and educational reports and special agents' reports leads to a question whether the government printers are not those chiefly benefited by the preparation and publication of such docu-

ments. For all the effect produced by them they might as well have been corked up in bottles and year by year cast solemnly into the sea; they would have had as much influence in the bellies of sharks and whales as in their respective pigeonholes at Washington. Thirty years ago the same needs were urged, the same glaring faults and incongruities of administration were pointed out, the same suggestions for improvement were made, "most earnestly and respectfully," as appear in the reports to-day.

The few places referred to by Governor Strong where medical aid to the natives is furnished by the Government are mostly on the coasts; for the whole of the interior a makeshift hospital at Nulato is the only government provision, unless the supplying of some drugs and bandages and liniments to school-teachers without any medical training be counted; and Nulato is upwards of 500 miles from Fort Yukon. What has been gained from Congress for the care of the natives has been gained by the ceaseless importunities of the Bureau of Education. Last year the bureau succeeded in securing an appropriation of \$50,000, instead of the \$25,000 previously appropriated for medical relief, but the present appropriation would have to be multiplied a number of times to enable the bureau to cope with the conditions.

So the hospital at Fort Yukon, which itself cost \$25,000, and has a maximum accommodation of twenty beds, is part of a plan to supply the deficiencies of the Government. It receives and cares for sick or injured natives regardless of any consideration except the needs of the individual case; it even sends for them and brings them in by a dog team in the winter and a launch in the summer, if there be no other ready means of their coming. It does not care whether they be Alaskan or Canadian Indians (an often impossible distinction amongst people some of whom shift their residence back and forth across the international boundary as freely as they did before that line was drawn). If they be in need of medical attention, they are welcome to the best we can give, without any charge whatever.

But while primarily a native hospital, it does not refuse white patients—how could it when there is nowhere else to go? It reserves a room for them, and in the three years in which it

has been in operation has received a number from far and near. The first patient of any kind, before the hospital was really open, was an old-timer of the Yukon who had frozen both his feet severely, a case that called for long detention and much tedious, careful surgery. The second white patient that I recall was a very striking case, a woman whose head was nearly cut off by falling against a revolving saw; fortunately, despite the fearful lacerations of her neck, the great blood-vessels were not severed, and, to the astonishment of everyone, she recovered. I shall never forget the ghastly sight as she was borne to the hospital on a door; she looked as Mary Queen of Scots might have looked had the executioner fumbled his blow and a reprieve arrived before another could be given—her gray hair all dabbled in her blood. Early last spring an explorer, suffering from complications following a long siege of typhoid fever, was hauled 400 miles or so by dog-sled from the arctic coast, and when he was entirely recovered he told me that he believed he would have died had he not come here, though I think his restoration to health was due as much to the long journey in the open air as to the treatment at the hospital. Last summer a woman, taken suddenly ill on a steamboat, was brought ashore on a stretcher, and the captain said: "Thank God for this hospital; I thought she would have died on my boat."

Nine-tenths of the work done by the hospital is, however, native work; and just as soon as one begins to talk about native hospital work, tuberculosis thrusts up its ugly head, above all accidents, above all diseases whatever, for it is the scourge of Alaska, just as it is the scourge of our great cities. Of the ninety deaths recorded since our resident physician, Doctor Grafton Burke, came to Fort Yukon, forty-six are set down as due to tuberculosis in some form or other, with suspicion of the same in other cases, so that we may say that there are more deaths from tuberculosis than from all other causes put together.

Whether or not this disease were known before the white man came to the country seems uncertain, physicians with experience amongst the natives, and even the oldest natives themselves, holding contrary opinions; but it is certain that if the disease be indigenous, its ravages have greatly increased since

the white man's coming; for which there is sufficient explanation in the change of habits which intercourse with the whites has brought about.

Tuberculosis in the arctic regions is fostered and is checked by the same causes that foster or check it elsewhere; and a people of wandering tent-dwellers changed by the introduction of edge-tools into a people of more stationary log-cabin dwellers, a people of fur-wearers changed by the constantly increasing market for pelts, and the introduction of manufactured clothing into a people, in the main, of cotton-wearers, present as favorable conditions for the growth and dissemination of this disease as do those who have migrated from the sunny vineyards of Sicily to the slums of New York.

Resumption of the primitive Indian conditions of life, however desirable it might be from an exclusively hygienic point of view, is out of the question; the influences against it are entirely too strong. The remedy must be sought in improving the new conditions rather than in a return to the old. That improvement goes on, slowly but surely; the cabins become more commodious and better ventilated; personal habits more cleanly; the rules of health more generally known and observed. If there be any way in which such improvement may come other than slowly and gradually, those who are working for the Yukon Indians have not discovered it. It is only in theory, I think, that such things are done out of hand.

Meanwhile the hospital performs a function of very great value to the upbuilding of the general health in receiving cases of incipient tuberculosis and subjecting them to a régime of recuperation such as cannot be carried out save in an institution of this sort. Children who give early warning of pulmonary lesion, children with broken-down and suppurating neck-glands—that common and offensive evidence amongst Indians of tuberculous invasion—improve often into perfect health; and there are already a number whose lives have thus been saved. One of our two wards is set aside for such cases, and at the present writing has five children in it.

There are great and special difficulties in conducting a hospital in the arctic regions. It is, of course, well understood by those read in geography, though not yet, I think, in gen-

eral, that the extremes of the world's cold are to be found in continental interiors, such as Alaska and Siberia, and not in the marine climates of the shores of the most northerly lands. A greater degree of cold is recorded every winter at Fort Yukon than any that Admiral Peary encountered on his journey to the North Pole. The lowest temperature I can find in the account of that journey is -59°F. , while at Fort Yukon a temperature of -68° is not uncommon, and I have myself recorded a temperature of -72° in the Yukon Flats. Temperatures fluctuating between -50° and -60° sometimes last for weeks at a time. A plus temperature in December or January is a very rare thing, and is sometimes entirely lacking in the months of November and February also.

The difficulty, obvious enough, of the proper steady heating of a large building under such climatic conditions, with wood as the only fuel, is not the greatest one; the water supply is more onerous and painful. Hospitals require much water, and the supply cannot be stinted without detriment. Moreover, this hospital is lit by an acetylene-gas plant, which in the dead of winter consumes 250 gallons a week. Where every drop of water must be obtained by breaking open afresh a hole in the river ice (which attains a thickness of from four to six feet during the winter), dipping it out into a tank on a sled drawn by dogs, hauling it up a steep bank, and to the hospital door, and then carrying it in buckets to the various receptacles throughout the building, the provision of this prime necessary becomes the heaviest daily task in the conduct of the institution, and has no counterpart at all in hospitals "outside."

So onerous and painful did it become that almost any expense that could be compassed seemed justified in an attempt to remove it, doubtful of success though the attempt might be.

At first we tried for a well. With a prospecting boiler and steam-points we sank 130 feet through frozen sand and gravel without any success. That is, I think, the deepest hole ever sunk in the Yukon Flats (which is not a mining region), though elsewhere in Alaska holes have been sunk more than 300 feet without getting through the frozen ground, and since we struck no "thawed streak," and therefore no water, it seemed useless going any farther. Then we tried another plan.

From a level in this shaft below the lowest water in the river we drove a tunnel, by the same means, right out to the river, tapping its bed, a distance of 170 feet. The first tunnel was too small and froze up; so we thawed it out with the steam-points and enlarged it. Now we have plenty of water in our shaft, and since it has stood nearly through one winter without freezing up, we begin to be reasonably sure of its permanence. But, strange to say, though the free connection of the water in our shaft with its source of supply is proved by its rising and falling as the river rises and falls, the water is so heavily impregnated with alkaline salts as to be of little general use.

One would hardly believe that the soft, excellent water of the river could be so changed in character by passing through a short tunnel, and one can only suppose a layer of some very soluble mineral salts to lie along its walls or under the bed of the river.

So the dog-sled, with its galvanized-iron tank, still goes down to the river and brings up water from beneath the ice for cooking and drinking and laundry, and there seems little prospect that our winter supply of potable water can be secured in any other way, though the tunnel may scour out and its water improve in course of time. The well is worth what it has cost, for bathing and scrubbing and acetylene water, but it is a great disappointment that it falls so far short of the relief it was expected to provide.

Fairly well equipped in a general way though St. Stephen's Hospital is, further provision must be made if it is to work most efficiently for its tuberculous patients. The treatment by fresh air and sunshine which yields such good results elsewhere is equally valuable here, but again the climate interposes special difficulties. In the summer there is continuous sunshine, but there is also such a plague of mosquitoes and flies that much of the time it is impossible to expose any part of the body outdoors without nets and veils; in the spring and fall there are many bright days, but they are commonly attended by a keen wind that equally forbids exposure.

What is needed is a "solarium," a chamber of glass sashes, completely screened from insects, in which advantage may be taken of all the sun of the year; in which children may be

exposed naked to its germ-destroying and invigorating rays. Such an addition would be of great help in the most hopeful part of our medical work, the abortion of incipient consumption and the restoration of invaded glands. In these last-mentioned cases it is sometimes wonderful to see the contracting and closing of open neck sores, the gradual overspreading of the places with new, healthy flesh and skin, under no other treatment than prolonged exposure to direct sunshine.

The cementing of the basement, now merely an excavation in the earth, so that it may be utilized for laundry purposes, is also much needed, proper hospital economy in these parts demanding that all possible activities be gathered under the one roof. And the problem of drainage is only temporarily solved by a cesspool which it is very difficult to keep open in winter.

As it stands, however, St. Stephen's Hospital has already brought new hope to those who are laboring for the survival of the Yukon Indians, and now that the cessation of the war will allow the staffing with physicians and nurses of the sister institution already built and equipped at Tanana, 350 miles farther down the river, that has awaited its staff these three years past, we shall attack the problem of disease amongst the natives of the middle river with some prospect of coping with it.

Here is an immense country, inhabited from immemorial times by a vigorous, self-supporting native people; a country that is never likely *me judice*, so far as much the greater part of its whole area is concerned, to have any other inhabitants. There is no doubt that it once supported a much larger population than it does to-day, and there is no doubt that it could support to-day a much larger Indian population than it does. It is still a fine Indian country and it shows no sign of even a tendency to become anything else. If any notion has been entertained of white men pressing upon the Indian lands of Alaska as they pressed upon the Indian lands of our Western States, let it be dismissed at once as utterly without foundation.

Of late years there has been much extravagant stuff written about Alaska. Fifty years ago the country was laughed at as "Seward's Folly," and a general impression obtained that it was a land of permanent ice and snow. Now it is glowingly

described as "the world's treasure-house of mineral wealth and agricultural possibility;" and there is as much truth in the one extreme as in the other. The favorite term for its mineral wealth to-day is "incalculable," and I have no quarrel with the term; where there are no figures there can be no calculation, and, save as regards gold, the mineral resources of the interior are virtually unknown. Its swamps and scrubby woodlands and tundra are spoken of as "millions of acres waiting for the plough," and I do not take exception to that phrase either; they are undeniably waiting.

Setting aside the mineral wealth, which is doubtless great (though probably entirely non-existent in the region of the Yukon Flats), the agricultural possibilities of the interior are in reality very slight compared with its vast area, and those who are really familiar with the interior know that its main resources are never likely to be other than they are now—fur and game and fish. But fur and game and fish are precisely the resources that make a fine Indian country.

Is there any sense in permitting a country to be deprived of the only inhabitants it is ever likely to have? In all the wide region north of the Yukon, and in much else of its interior area, a prolonged winter of rigorous, inclement weather, an intractable soil, forbid to any sober eye the settlement of the country with farms and ranches, forbid its occupation by white men unless they are willing to live as Indians live, to become, economically Indians. Speaking broadly, all the white men who live north of the Yukon, save a handful here and there engaged in the temporary occupation of placer-gold mining, are married to Indian women; and the number is very small.

I can see no economic threat to the survival of the natives of the interior unless the iniquity of salmon canneries be permitted at the mouth of the Yukon, for the fish that annually come up this great river constitute the staff of life of man and of man's indispensable servant, the dog. In the course of generations it might be possible that our ichthyophagous, carnivorous Indians could be trained to live upon turnips, as the fish-canners and their friends so considerably suggest they should do; but I have grave doubts about the dog. And certainly to-day to intercept and capture the migrating salmon will bring starvation to man and beast, just as surely as intercepting and

capturing the railway trains that carry flour to New York would bring starvation to the metropolis.

Last summer a beginning was made; a cannery was permitted at Andreafsky, just above the junction of most of the delta mouths, and almost all the king salmon caught here in the Yukon Flats bore marks of the nets from which they had managed to escape a thousand miles away. Another season the nets will be stouter or of finer mesh, and should this wicked thing still be tolerated, despite all our protests, a race of self-supporting and inoffensive people, scattered over some hundreds of thousands of square miles, will be sacrificed.

I was struck last summer by the spectacle of our Indian people contributing to the relief of the starving Armenians, themselves dismayed at the meagre catch of net-marked salmon, and at the threat of starvation which those net-marks told them plainly enough hung over their own heads.

The only other threat to the survival of the race, now that intoxicating liquor is excluded from the Territory, is the threat of disease—of the white man's diseases, smallpox and diphtheria, and measles, and now influenza—and, above all, tuberculosis. The influenza epidemic has not yet reached the interior, thank God, but we are not without apprehension of what next summer's navigation may bring. The tuberculosis threat we believe we can avert; and are actively engaged in that aversion, and desire only more power to our hands along the lines we are pursuing. Already we have reason to believe that the corner is turned.

I may, perhaps, hardly call our Indians a "bold peasantry," and certainly they are not "their country's pride;" their country is quite indifferent to them; their country will spend \$50,000,000 on a railway, but cuts down every year the modest sums asked by the Bureau of Education for their medical care. Such as they are, however, a docile, gentle, industrious, intelligent, and, along their own lines, enterprising folk, I am convinced that "once destroyed" their place "can never be supplied;" and surely an inhabited wilderness is better worth any country's while than an uninhabited one. Goldsmith's hackneyed lines apply just as cogently to the Alaskan Indians to-day as they did to his Munster crofters of nearly two centuries ago.—*Scribners' Magazine*.

Hospital Items

MOWAT HOSPITAL FURTHER LEASED TO GOVERNMENT

AT a meeting of the Kingston Health Association on February 10th, the Sir Oliver Mowat Memorial Hospital for tubercular patients was leased to the Dominion Government for a further term of two years, and thereafter the lease will be made year by year, as required. This hospital has been used by the Government during the past five years for returned soldiers, and is at present operated under the direction of the D.S.C.R. There are now 125 patients being cared for in the institution, and the Government has expended \$200,000 in extensions and equipment.

WILL SUBMIT BY-LAW FOR HOSPITAL BONDS

THE submission of a by-law providing for the issuance of \$125,000 in debentures toward the erection of the proposed Elgin Memorial Hospital was authorized by the City Council of St. Thomas, at a special meeting on January 17th, provision being made that all returned soldiers who are residents of St. Thomas or Elgin County at the time of enlistment be given free treatment, care and maintenance in the institution as long as they require it. A deputation from the Memorial Hospital Committee waited on the County Council at its inaugural meeting the following week and petitioned for a grant from the County.

HOSPITAL'S BIG DEFICIT

AT the ninety-sixth annual meeting of the Montreal General Hospital on February 15th, the deficit for 1920 was shown to be \$84,000, and "I cannot hope it will be less for 1921," the Superintendent stated. It was shown that out of 5,810 patients admitted to the hospital during 1920, total deaths were 415.

TO INSPECT D.S.C.R. HOSPITALS

THE Honorary Superintendent of Soldiers' Comforts for Canada, Mrs. Arthur VanKoughnet, left recently for the Maritime Provinces and Quebec, to inspect and confer with the officers and medical directors commanding the D. S. C. R. hospitals. Mrs. VanKoughnet's visit to the hospitals in Nova Scotia, New Brunswick and Quebec is at the request of the Department at Ottawa, and shortly after her return she will visit the D. S. C. R. hospitals in the Western Provinces, as well as British Columbia. Soldiers' Comforts has enlarged its sphere of work, adding several branches which have been most successful.

CONSIDER NURSES' HOME

THE Board of Health of Toronto held a special meeting in Dr. Hastings' office on March 22nd to consider the site of the new Nurses' Home for the Isolation Hospital. Part of the plans have been completed and the department is anxious that the work should proceed immediately. The proposed site is on the jail grounds adjacent to the governor's residence. The Building will be situated back from the corner of Gerrard Street and Broadview Avenue.

It is expected that 150 nurses can be housed in the new building. The transfer of the nurses to the new building will release more space for the treatment of patients. At present the hospital is greatly overcrowded. Only patients from rooming houses and other places where quarantine conditions cannot be placed are taken in. The estimated cost of the building is \$300,000.

SITES ARE PROPOSED FOR WHITBY HOSPITAL

DR. McKAY, Inspector of Prisons, Hospitals and Asylums, and Mr. James Govan, Chief Architect in the Provincial Secretary's Department, on February 28th inspected the two sites pro-

posed for the new Ontario County Memorial Hospital, at Whitby. At a meeting of the Hospital Board they advised, if a new hospital were built, its capacity, at the least, should be twenty-five beds. It would cost from \$2,000 to \$6,000 per bed to erect a suitable building, they stated.

If the house of the late Dr. Warren were used as a hospital it could be renovated and equipped at a cost of about \$20,000, to accommodate ten beds. The average cost of running a hospital in Ontario was \$2.99 per patient per day, Dr. McKay stated.

NEW HOSPITAL WING FOR INDIAN PATIENTS

Work on the Indian wing of the Lady Minto Hospital at Cochrane, Ont., is progressing rapidly. The building is required for the use of the increasing number of Indian patients being treated at the hospital. Some of the patients have come from the shores of James Bay, four coming from Moose Factory last year. The Department of Indian Affairs at Ottawa has contributed nearly \$5,000 toward the cost of the new addition.

FIRE AT ORCHARD HOUSE

To presence of mind on the part of Superintendent Dr. W. M. English and other officials of the Ontario Hospital for the Insane, Hamilton, is attributed the rescue of 161 female inmates from fire, which, on February 23rd, gutted the women's wing of the Orchard House, one of the three largest buildings of the hospital, doing damage estimated at \$50,000 or \$60,000.

Energetic action by the staff and prompt response by the city fire department and by near-by citizens, resulted in confining the flames to the two upper floors of the women's wing. Stout fire walls separated this wing from the remainder of the building which would otherwise probably have been entirely destroyed. Comparatively little disorder was created by the

blaze, and all the inmates of the burned building have been accommodated in the main building.

Cause of the fire is still unknown. The flames broke out first in an unoccupied attic room. They were discovered, apparently about the same time, by plumbers working on a lower floor, and by an inmate in one of the other buildings. The alarm was promptly given, both by 'phone to the city fire department, and by the blowing of the hospital's siren, which resounded throughout the whole city.

Work of conducting the inmates of the burning building to safety was at once undertaken by Dr. English and other officials, and carried out with remarkably little disorder. Only one woman, bed-ridden, objected to being removed, and she was carried out by two attendants.

Work of the firemen was beset with obstacles. The road up the mountain-side was in an exceedingly slippery condition, and a high wind had aided in spreading the flames by the time the fire fighters arrived. Fragments of slate, cracked from the roof by the heat, fell in torrents, and flying sparks threatened other buildings near-by. In view of the hazardous conditions which obtained, it is considered fortunate that there were only two accidents recorded: Fireman William Blackwood was overcome by the dense smoke, while Robert Hardstone, assistant gardener, fell twenty feet from a low roof to the ground, sustaining nothing more than a severe shaking-up. Dr. English himself was drenched with water, but continued to lead the rescue work.

Residents of the district responded readily, and lent their aid in salvaging furniture from the building, with the result that only a few iron beds in one of the dormitories were destroyed. The inmates also joined readily in the work of salvage. By half-past one the flames were under control.

Several inmates of the institution took advantage of the outbreak to attempt escape and two succeeded in finding their way down the hillside to the city, where they were taken in charge on John Street, and returned to the hospital. One woman, lightly clad and without shoes or stockings, was found wandering in the snow in the hospital grounds, and was given

prompt medical attention to counteract the effects of shock and exposure.

W. W. Dunlop, Inspector of Asylums and Prisons for Ontario, arrived on the scene early, accompanied by Mr. A. E. Semple, of the Provincial Secretary's Department, and Fire Inspector William Crawford, and Messrs. A. J. Rattray and E. M. Allen, of the Public Works Department.

Officials were at a loss to account for the fire, and were rather inclined to set it down to spontaneous combustion. The attic room where it originated was unoccupied and was not even used for storage purposes. The conduit system of electric wiring, it is said, precluded any possibility of defective wires.

The Orchard House is a brick structure, four storeys in height, and one of the oldest of the hospital buildings. It is located to the south of the other buildings, and was in the direct line of the high wind which blew all day. Fire Chief TenEyck gave high praise to the work of the firemen and staff of the hospital.

Female inmates of the Orchard House have all been accommodated in the main building. The male inmates, who were temporarily removed from their quarters, were able to return before night, their wing being untouched by the flames. Until further accommodation is provided, it will be necessary to send all fresh female cases to the Toronto hospital. Male patients will be admitted as usual.

There have been three previous fires at the asylum. The first occurred on October 31st, 1886; the second on August 1st, 1911, when nine lives were lost; and the last on April 23rd, 1916, when the other wing of the Orchard House was burned. Fire Chief TenEyck and Assistant Chief James, who led the firemen at the recent blaze, were both on hand at the first fire, thirty-five years ago.

NEW NURSES' HOME OPENED AT KITCHENER

THE new Nurses' Home, erected and equipped at a cost of between \$90,000 and \$100,000 by the late Jacob Kauffman and his family, was formally presented to the Kitchener-Waterloo Board of Trustees on April 1st, in the presence of a large number of civic representatives and friends of the institution.

NURSES' TRAINING SCHOOL AT BRUSSELS TO BE MEMORIAL TO EDITH CAVELL

ESTABLISHMENT of a Nurses' Training School at the Medical School, University of Brussels, in memory of Edith Cavell and Mme. Depage, who was active in Belgian Red Cross work during the war, and who lost her life on the *Lusitania*, will result from a gift of 43,000,000 francs for new buildings and endowments of the Medical School of the University of Brussels, announced by the Rockefeller Foundation on March 22nd.

The contribution by the Foundation follows a visit to the United States of members of the medical faculty. The Charities Board of Brussels and the University of Brussels, together with the Rockefeller Foundation, plan the expenditure of 100,000,000 francs in new buildings and equipment.

GRADUATE NURSES' ASSOCIATION

ADDRESSING the Graduate Nurses' Association on April 1st, his Honor, Lieutenant-Governor Lionel H. Clarke, spoke of the large number of nurses engaged in the Province of Ontario, although he was informed that the supply did not nearly meet the demand. It would be a serious mistake to allow any obstacle to stand in the way of securing a sufficient number of nurses to meet the requirements of every separate community within the province. He spoke with some intimate knowledge of the hospital training given to nurses, and of the skill necessary in the various branches in which they exercised their profession.

He touched upon the increased opportunities now offered in the Public Service Department, and in this respect commended the co-operation that was being advanced by the Red Cross Society, the Public Health Department of the province and many of the municipal authorities. The Public Health Department of the average city had now become one of its most important service agencies, second in importance to no other branch. The Victorian Order of Nurses, his Honor said, was

doing most excellent work and reaching classes where the need of such assistance as they were able to give was very much felt.

The Lieutenant-Governor emphasized the importance of a high standard of ethics within the profession, and held that public service of such a character as ought to merit public confidence was rarely denied public appreciation.

Other short addresses were given by Rev. Dr. Renison, Dr. J. Edgar Davey, Mrs. Henry Carpenter, Miss Fairley, President of the C.N.A.E.

A round-table discussion on university courses for nurses occupied the major part of the afternoon session. Mrs. George O'Brien, President of the Hamilton General Hospital Alumnae, conducted the discussion. Delegates spoke both for and against such courses, although it was admitted that the advantages of such courses were being more fully recognized, as was attested to by the general development such instruction was undergoing in Canadian universities. Miss Margaret McDiarmid, Supervisor of the course for public health nurses, Western University, London, read an interesting paper on the encouraging progress this branch of study was making. Such courses from the standpoint of the student were explained by Miss Blackstock, Toronto, and Miss Fraser, Western University, London.

Miss Jean I. Gunn, Superintendent of Nurses, General Hospital, Toronto, emphasized the necessity for nurses taking such courses, and felt that universities should look on these as a very important part of their curricula.

Miss Cameron opened the discussion on whether it is better for a nurse to specialize or to generalize.

The delegates and visiting members were entertained at afternoon tea by St. Joseph's Alumnae.

At the morning's session Dr. Middleton, of Toronto, stated that out of 60,000 babies born last year in Ontario, 1,000 died before reaching the age of one year. He urged greater public health endeavor. The public were ignorant of health laws, and there was a lamentable shortage of nurses in the North country. Tuberculosis was the cause of many deaths.

Miss Jamieson, President, gave a paper on the "School Health Plan for Ontario." She announced that a survey of all rural schools in Ontario would be attempted.

Miss Maddock, nurse in the McClary factory, London, gave a talk on "Industrial Nursing."

The Association decided to ask the Canadian Red Cross to undertake the enrolment of nurses for emergencies.

Dr. Holbrook, Medical Superintendent of the Mountain Sanitarium, said 90 per cent. of the children in rural schools were defective, and 85 per cent. of all children in the province had one or more defects.

The nurses were entertained at dinner by the Hamilton Medical Association.

Dr. J. K. McGregor, a surgeon who addressed the convention on "Pain," said he believed in Christian Science to the extent that it was helpful to patients who were so highly developed mentally that they were able to make mind predominate over matter. Faith and religion were both able to reduce pain, but their influences were only temporary. He said there were many kinds of pain—imaginary, hysterical, superficial and actual, and all presented their problems.

Foreigners, because they were unable to understand our language and methods, suffered more acutely than Canadian-born. They could not be reassured, and fear caused pain.

More injury was caused by pain than by surgical operations, and in spite of all objections to the use of drugs their worth was quite apparent. When a nurse could decide between actual and hysterical pain she had attained a high degree of efficiency.

The Association will continue its Advisory Committee to work with the Red Cross. An educational memorial was decided upon in honor of the nurses who sacrificed their lives during the great war; a scholarship will be established.

The following new directors were appointed: Miss Hanna, Hamilton; Miss Bilger, Kitchener; Miss McArthur, Owen Sound; Miss Jamieson, Toronto; Miss Boyes, Hamilton, and Mrs. Anderson, Ottawa.

NEW NURSES' HOME, CITY HOSPITAL, HAMILTON

THEIR views still antipodal respecting the merits of single and double bedrooms, no settlement was reached by the members of the Board of Control of Hamilton and the Board of Hospital Governors when plans for the new Nurses' Home were discussed from almost every angle again on March 18th. The only decision made was to have the architect call for tenders for a home having single rooms. In this way it is felt that the cost of the building can be determined. The basement may or may not be finished.

Many letters from hospital experts, eminent physicians and lady superintendents of hospitals were produced by Dr. Langrill to show how desirable it is that each nurse have a room to herself. He added that nurses were rightfully discriminating these days in demanding that they be accommodated with single rooms. Moreover, if a hospital wished to turn out nurses who would be a credit to it, single rooms were highly essential.

T. H. Pratt, Chairman of the Board of Hospital Governors, echoed these sentiments. He would never consent to nurses being placed two in a room, and to emphasize his point, mentioned that 40 Hamilton girls had signed up with a Buffalo hospital to commence their duties early in April. These young women, no doubt, he thought, would prefer to train in Hamilton, but conditions offered them in Buffalo were much more attractive. To begin with, they would work only eight hours a day, would receive \$20 per month, and, most important of all, would each have a room.

Mr. Pratt said Hamilton would very soon have to establish the eight-hour day for nurses, and to do this a modern Nurses' Home with single rooms was necessary.

Mayor Copley insisted that the building would have to be erected for \$200,000, as \$69,000 had already been spent in acquiring the site, while \$30,000 more would be needed for furnishings. His Worship held that when the ratepayers voted for an expenditure of \$300,000 they took it for granted that that sum would purchase the site, meet the construction costs and furnishings as well. His Worship felt that by having two

floors of the home constructed with double rooms, and two others with single rooms, the expenditure for erection would be kept down to \$200,000. In fact, it had to be, that was all, otherwise he would not consent to any more money being spent on the home.

"Well, I just want to say," rejoined Mr. Pratt, "that I will never consent to any double rooms. We have got to provide decent accommodation for our nurses, otherwise we might just as well close up the hospital. We have developed that hospital from a mere house of refuge to a modern institution, and we are not going to take the retrogressive step you want us to take, Mr. Mayor, when you suggest double rooms. That is ancient. We are aiming to keep abreast of modern requirements."

Tenders, it is expected, will be in at an early date, when the actual cost of the building will be known. Mayor Copley, however, made it clear that unless a home could be built for \$200,000 he would oppose single rooms and other costly appointments.

RECEPTION HOSPITAL TO BE BUILT AT ONCE

TORONTO's long-delayed reception hospital for observation of cases of supposed mental instability is to materialize at last. It is nearly two years since the Ontario Government refused to permit continued use of unsuitable premises in Trinity Park. The city will now have a modern building located near Toronto University and will be freed from the present reproach of sending to the common jail citizens whose only "crime" is an unbalanced mentality.

The announcement was made on March 23rd as the result of a final conference between Sir William Meredith, representing the university, and Ald. Burgess and Solicitor F. A. Eddis, representing the city. As a result of the good offices of these gentlemen, a building costing, with equipment, \$400,000, can be erected almost at once. The agreement will be ratified by city council at its next meeting. As soon as this is done, the university will commence to tear down the building now located on the site, so that the city can proceed with erection

of the hospital. The agreement reached is practically as follows:—

The university contributes a site on Surrey place at Grosvenor Street, back of Queen's Hall. In order that suitable surroundings may be guaranteed, it is agreed that adjoining buildings will not be extended farther towards this site than at present. The city does not get a deed in fee of the site, but an equitable estate; that is, the university holds it in trust for the city as long as it is used for hospital purposes.

On this site a reception hospital, on a plan approved by the Government, is to be erected and equipped at the expense of the city. It is to be staffed by the Government after consultation with the university authorities, and is to be maintained at the cost of the Government.

The university, in return for the site, is to have facilities in the building for psychiatric clinics.

The hospital will accommodate sixty patients. It is understood that in the cases of city order patients, a per diem allowance will be paid by the city, as is done in connection with other hospitals. The amount of this has not been settled. Otherwise, the city's only cost will be the initial capital expenditure.

While the agreement has yet to be ratified by the university governors, it is understood that this will be done as a matter of course. The building now on the site is known as the "Old Walker Home."

The American Pocket Medical Dictionary. Eleventh edition. Revised and enlarged by W. A. NEWMAN DORLAND, A.M., M.D., member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. Philadelphia and London: W. B. Saunders Company. 1919.

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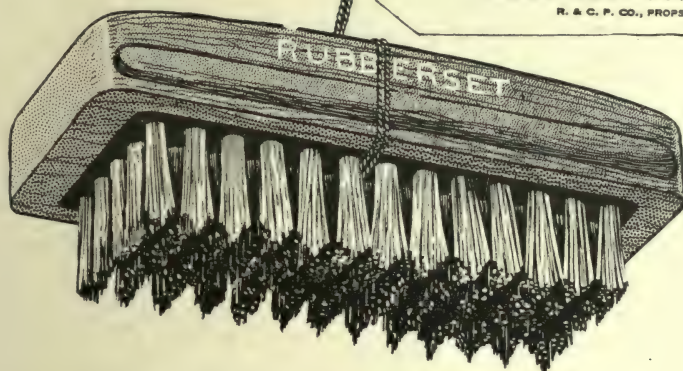
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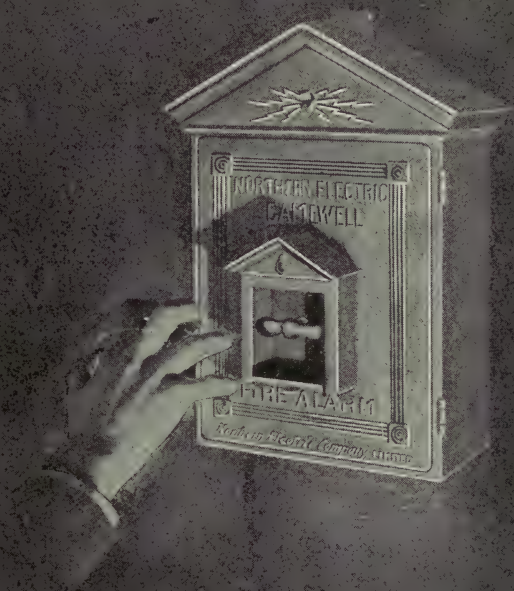
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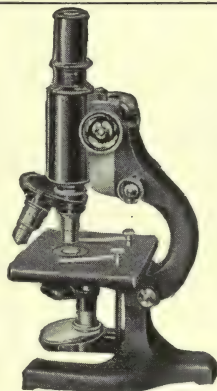
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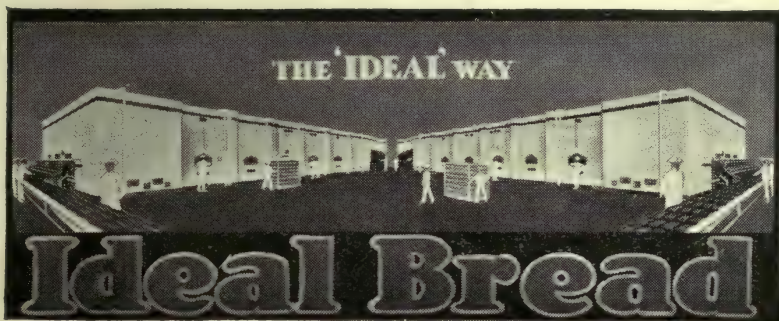
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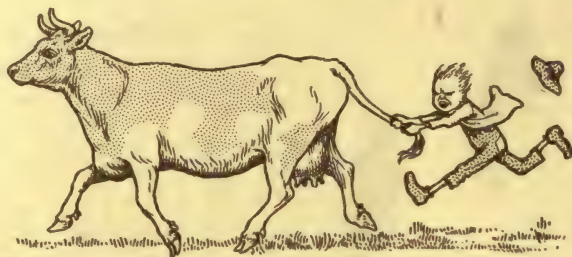
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THE HOSPITAL WORLD

Vol. XIX

Toronto, June, 1921

No. 6

CONTENTS

EDITORIALS

BOOK REVIEWS

An Operation in the Country	Page 169
Holidays in Hospitals	171

SELECTED ARTICLES

Canada's War Hospital Development. By J. H. W. Bower, B.A.Sc.	174
The Hazelton Hospital. By Herman J. Ferrier	188
Internship and General Practice.	191

Clinical Studies for Nurses.....	Page 194
The Psychology of Nursing	194
Eating to Live Long	195
Manual of Bacteriology and Pathology for Nurses	195
French-English Medical Dictionary	196
Materia Medica, Pharmacology and Therapeutics for Nurses	196
Bandages and Bandaging for Nurses	197
Eye, Ear, Nose and Throat Nursing	197

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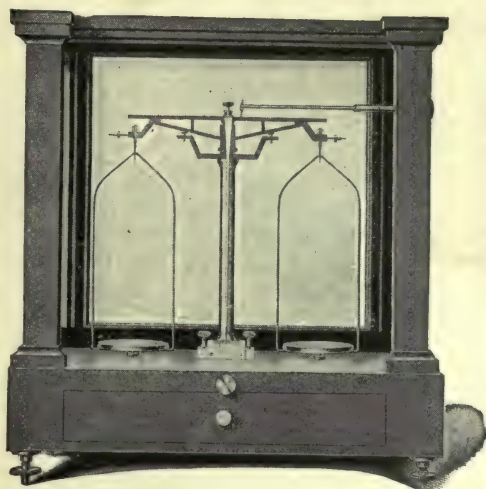
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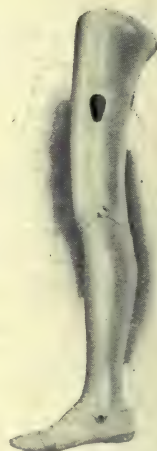
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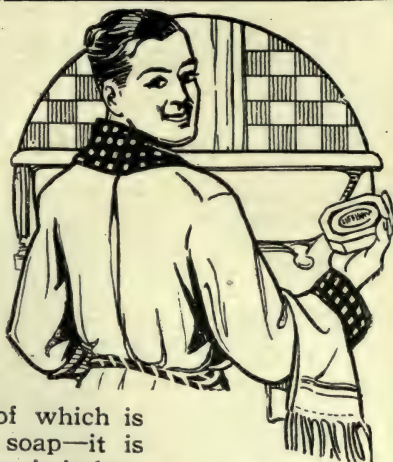
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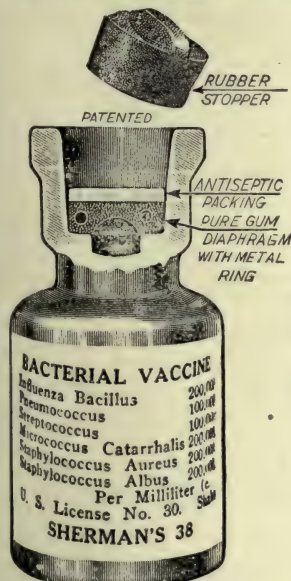
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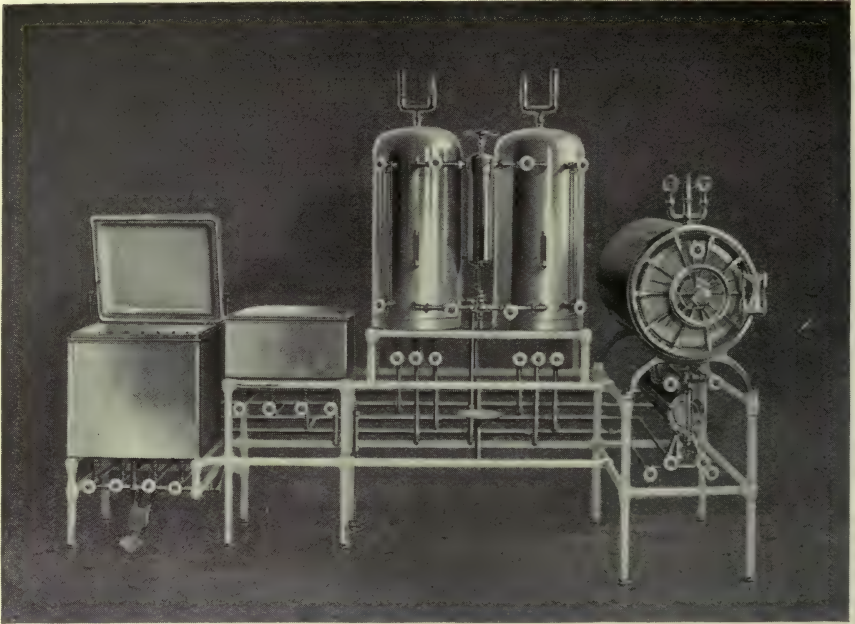
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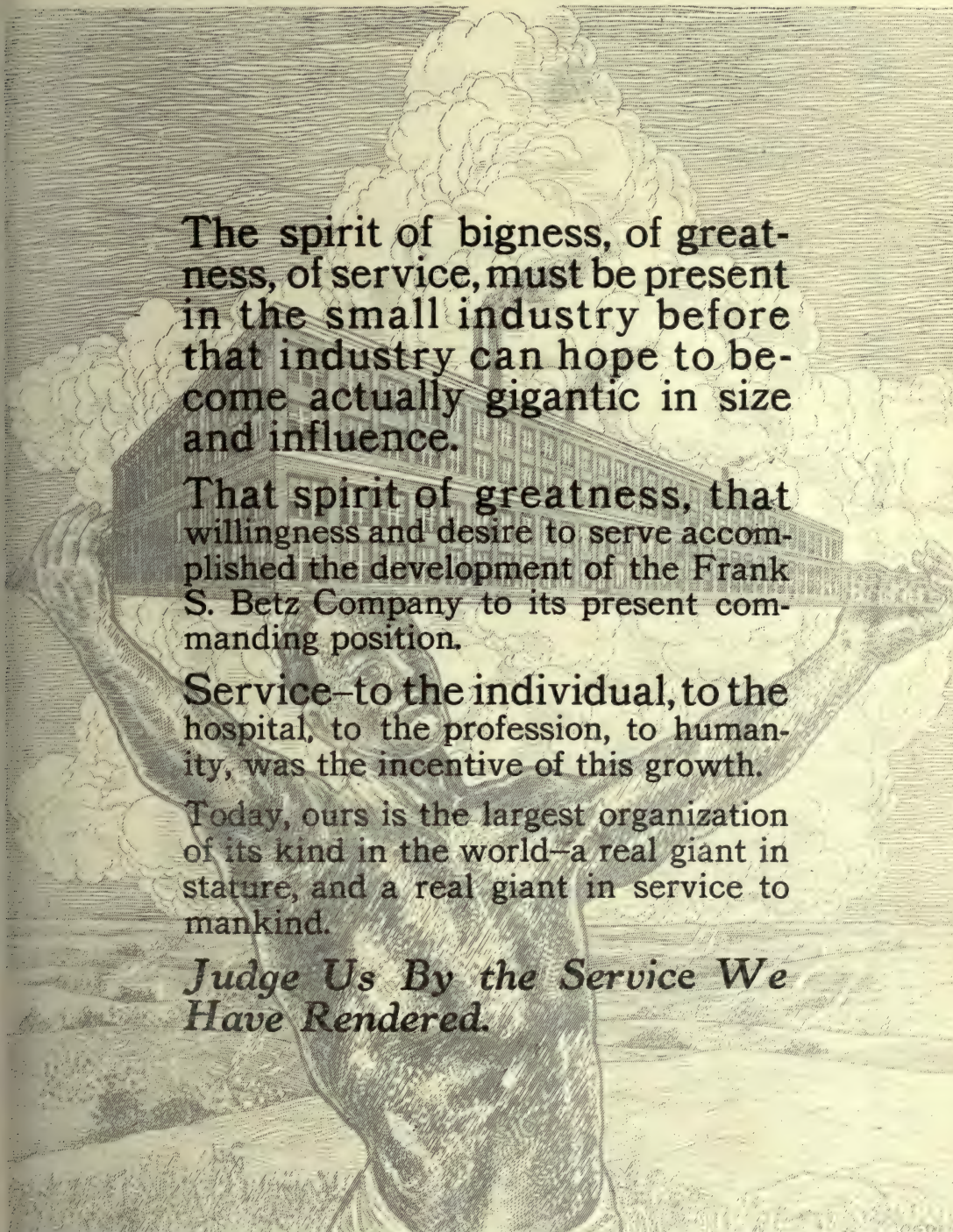
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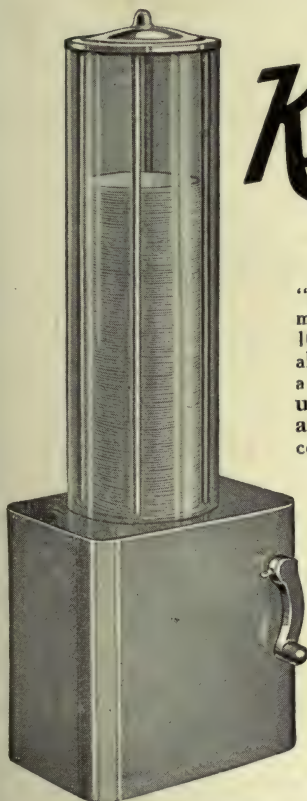
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire

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Editorials

AN OPERATION IN THE COUNTRY

LAST week the writer was present at an operation—a major one—in a farm house. The patient was almost *in extremis* from an unknown abdominal complaint, and refused to go to hospital for operation. One doctor—discharged—had diagnosed gall-stones. The gall-bladder and ducts, on examination were found normal. A second doctor, earlier on the case, had made a diagnosis of duodenal ulcer, or possibly “an appendix.” X-ray unavailable. Neither was found. The operating surgeon did find a hernia of the transverse colon through the greater omentum; a stricture—apparently simple—of the descending colon, and some injection of the sigmoid. There was paralysis of both bowels, with much distension and ballooning. Both bowels were punctured, allowing distending gases to escape, and the openings closed by purse-string sutures. The hernia was reduced; and the constriction bridged by an anastomosis. The local practitioner assisted.

H.W.—2

Dark supervening, a lamp was lighted. The nurse who held the lamp, having to go away, handed same to the assisting doctor. After holding for several minutes the nurse returned. Lamp passed back, and medical assistant, without thinking, proceeded handling intestines without re-washing. Time three hours. Anesthetic ether; trained nurse in attendance, who, with the surgeon, did the sterilization of gauze and dressing in an "Arnold" (non-pressure) on a stove. They boiled the instruments and utensils. Room of an old frame house heated by two coal-oil stoves—kept a respectable distance from the ether bottle and can. There was no thermometer in the room. There should have been. The table was not warmed. Warm water bottles or heat of some form should have been provided, as the room, in the writer's opinion, ought to have been kept somewhat warmer, especially when the length of operation is considered and amount of ether used.

It was the nurse's first major operation in a farm house. She had received one lecture on the subject of fitting up a room in a dwelling house for an operation; but had not seen an actual demonstration of such a room, such as is given as a routine to all the nurses of the Royal Victoria Hospital, Montreal.

The patient recovered from the operation, but within a few weeks developed a bad cough and later an empyema. Operation about six or eight weeks later for the empyema by removal of a portion of a rib. Patient succumbed a few hours later.

HOLIDAYS IN HOSPITALS

THE nursing profession has set all others a good example in the matter of holidays, viz., a month off each year.

This rule might well apply to doctors, orderlies, and all employees. To all conscientious people the work in hospitals is arduous and strenuous, particularly to those who have to do with patients. And living on the premises, as most hospital workers do, they become oppressed with the hospital atmosphere or aura, which is more or less baneful.

Ideally, all hospital employees, after eight or nine hours daily duty, should get away completely from the institution, where they may sleep and enjoy their recreations. This respite would enable them to return to duty much more refreshed than is now the case; and their influence on the patient would be more beneficial than is now the case.

Hospital workers are now considering how they shall spend their summer vacation. Those on service in Canadian hospitals are particularly fortunate. There are hundreds of trips which may be taken without great expense; and this is an important point to most members of hospital staffs.

The mountains are easily accessible to the British Columbians and Albertans. The sea and the wilds are within easy reach of all Maritimers on either seaboard. Quebec has hunting and fishing on her sequestered wilderness lakes and hunting in her rough, timbered areas; also the wonderful St. Law-

rence, with its islands and shore resorts, with boating, bathing and other forms of amusement.

Ontario has the Great Lakes all about her, the Thousand Islands; Niagara with her gorge and falls, teeming with interest to those interested in scenery or naturalistic studies; and Muskoka with her bays and islands, little rivers; her rocks and evergreens, and flowers. Wonderful air, beautiful skies and lovely environs!

One could go on indefinitely to speak of the hundreds of attractive spots in this great country, where weary men and women may recuperate and enjoy recreation.

We trust all hospital authorities will insist on giving their workers a good holiday with full pay.

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CANADA'S WAR HOSPITAL DEVELOPMENT

BY J. H. W. BOWER, B.A.Sc.

Late General Superintendent, Engineering Branch, Department Soldiers'
Re-establishment;
Now Hospital Consultant, Soldiers' Civil Re-establishment.

THE general considerations which led to the policy of establishing a chain of hospitals has been previously reviewed at some length.

The effectiveness of the policy so established largely depended upon the rapid design and construction of the institutions proposed.

It was realized that this problem was one without precedent in the history of Canada, and that its actual working out must be one of experimentation. At the same time, the experimental stage could not prolong itself into a period of months or years, as the necessities were of an immediate nature, due to the rapid return of disabled members of the Canadian forces from overseas. The engineering branch of the department was, therefore, immediately organized to take care of the work, in order that a central control within the existing organization might handle the many varied problems that had to be faced.

This branch of the work came into being during the fall of 1916, and the success of its work is acknowledged by experts from other countries who have inspected the various institutions throughout Canada.

In Europe, hospital facilities became an immediate necessity at the commencement of hostilities. It may, therefore, be imagined that the large institutions erected for war purposes in France and England would form concrete examples of what should be followed in Canada. By the time the department was faced with the hospitalization problem, plans and reports from war hospitals in France and England were available. These were surveyed in every detail, but it was found that climatic conditions in Canada prevented the very temporary type of structure from being used in this country. The type of struc-

ture generally used throughout England for war purposes, consisted of the lightest one-storey frame construction. The temperate climate of England and France made it unnecessary to have elaborate and complete heating systems installed, and for the same reason, the structural details of their buildings could be of the most temporary nature, provided the general inclemencies of the weather could be guarded against.

The climate of Canada being subject to great extremes, especially in winter, made it necessary that the institutions which were to care for sick and wounded men must be constructed that they could be easily and economically heated. At the same time, it was realized that the Government could not justify the construction of institutions of a permanent nature, as a great many of the hospitals erected would only be in use for a comparatively few years.

Thus, the problem which confronted the Department was a unique one without precedent. On the one hand, the usual type of hospital was out of the question, due to its high constructional cost. On the other hand, the purely temporary building was useless, due to the extreme climatic conditions encountered. An intermediary course was, therefore, adopted, and buildings were constructed along lines that might be termed "semi-permanent." It was found that buildings of this nature could be most economically constructed of two-storey heights. Generally speaking, the foundations of the buildings consisted of wooden or concrete posts, supporting a floor system designed to meet the proper loads. The walls of the superstructure were composed of studding, sheeted inside and out with T. & G. boarding, the interior and exterior sheeting being covered with two-ply of heavy building paper, and the finished interior surface being of some fire-resisting board, such as linabestos, gypsum fibre board, etc. The exteriors of the buildings were finished in stucco, applied to some such material as stucco board, lath board, metal lath, etc. The roofs of the hospital units were along the simplest lines possible.

The buildings, while having their general constructional members composed of inflammable materials, may be considered as being of the "slow burning" class. The interior walls and

ceilings were composed, as has been noted, of fireproof materials which would materially resist the spread of a fire making a start within the building. The exteriors of the buildings, due to the stucco finish, were also fire resisting, the only wood visible being that of the window frames and cornice trims.

While it was possible, by the adoption of the semi-permanent type of structure, to keep costs to less than half that of modern hospital construction, in so far as the actual buildings were concerned, the same degree of economy could not be consistently followed with reference to heating systems. These had to be of such efficiency as would meet the extremes in climate encountered during the Canadian winters. It was, therefore, necessary to go through practically the same course in installing heating and power plants as would have been encountered in work of a permanent nature. In war hospitals constructed in countries of more temperate climates, stoves were largely used for heating purposes. It was contended by some that a similar procedure could be followed in Canada, provided the buildings were properly constructed. Such practice was proven to be most impracticable, and it was definitely shown that taking into consideration the fire hazard, the discomfort to patients, and the coal consumption from operating so many units, the use of stoves would prove to be so uneconomical and dangerous in operation, that the installation of complete heating systems was easily justified.

The provision of sanitation, ablution facilities, and all those requirements peculiar and necessary in the operation of hospitals, falls, to a large extent, within the same class as that pertaining to the heating system discussed in the previous paragraph. While great economy could be followed in the structural type of the building used, plumbing and ablution facilities had to be adequate and properly designed to meet all conditions. It was necessary that all institutions erected be supplied with the most up-to-date hospital fixtures obtainable, in order that those operating the institution might be properly aided in giving effect to their professional skill. One step towards economy in this direction was possible, and resulted in enormous savings to the Department. In civilian hospitals usually erected, vitreous china fixtures of expensive patterns

have been used. The price of these fixtures during the period of the war doubled and trebled, and were at the same time almost impossible to obtain. By close co-operation with manufacturers of sanitary equipment, iron fixtures were designed, on which was used an acid-proof enamel. This enamel would not deteriorate from the use of strong acids generally in use in institutions of this kind. The costs of these fixtures were only a fraction of that of the usual type. Their present excellent condition is proof that their anticipated qualities have been realized.

FOOD SERVICE DEPARTMENTS.

The problem of food service in any institution is one which probably gives rise to more criticism by the patients than almost any other feature. In the war hospitals built in Canada, kitchen and dining-room lay-outs were considered and planned with the utmost regard to detail. Efficient and economic food service is largely dependent upon the dietary branch, having at its command complete and up-to-date facilities for food preparation. It has been demonstrated that the complete kitchen units provided have given a service second to none in the country. The installation of up-to-date equipment such as jacketted kettles, electrically driven apparatus, Hobart mixers, potato parers, dish washers, equipment for the making of ice creams, specially designed pastry ovens, batteries of toasters, and so forth, made it possible for those in charge to render such prompt and satisfactory service that, generally speaking, criticisms from the patients have been very noticeable by their almost entire absence.

One of the somewhat unique features connected with food service in Canadian war hospitals was the early adoption of up-to-date cafeteria systems, utilized by those patients in the institution who were well enough to serve themselves. The cafeteria system was installed wherever possible, and it has met with unqualified success. The system was entirely satisfactory to the patients, and the saving effected by the reduction in the number of serving staff lowered the patient cost of food to a surprisingly large extent.

For those whose disabilities confined them to their bed, each ward was equipped with a complete diet kitchen. The main kitchen supplied food for the whole institution, and proper amounts were distributed to each diet kitchen by means of heated food trucks. The diet kitchens were properly equipped for the preparation of all special diets, and by the use of steam heated appliances such as steam tables, etc., meals could be served at any specified time throughout the day.

Economic food service is largely dependent upon the purchasing of food supplies in large quantities. This policy was made possible by the installation of mechanical refrigeration operating large refrigerators in specially designed store-rooms.

HOSPITAL APPLIANCES AND EQUIPMENT.

Reference, in the foregoing part of this book, has been made to the wonderful work of the physician and surgeon during the war. Any professional skill can only obtain its greatest efficiency when properly aided by the most up-to-date appliances and general conditions. Operating suites instituted in Canada's war hospitals were complete to the last detail. The major operating suite in an active treatment institution was designed to embody all necessary departments in proper relation to the operating theatre itself. Sterilizing equipment of proven efficiency was installed in every such unit. In short, every piece of equipment necessary to aid skilful work was incorporated in each lay-out. The same careful degree of thought was used in the planning and allocation of space for X-ray departments. Many features not usually encountered in this work were embodied in the plans, and the results obtained have proven their efficiency. Perhaps one of the features which may receive more special attention was the complete facilities afforded in certain of the institutions for the carrying on of hydro-therapy, electro-therapy and mechano-therapy. It is doubtful if more efficient and complete departments of this nature exist in any of the civilian hospitals on this continent. Hydro-therapy installations consisted generally of continuous baths, arm and leg baths, Scotch douche with control table, steam cabinets, and so forth. The electro-therapy

branch of the work was equipped with every appliance proven to be of value in the treatment of certain disabilities. Considerable space and equipment was allocated for the use of the massage department, in order that the efficiently trained staff specializing in work of this nature might give full effect to their professional skill.

For the carrying on of special work, such as examinations in eye, ear, nose, and throat disabilities, each institution requiring such facilities was equipped with complete clinics in each branch of the work. In many of the institutions a great deal of out-patient work was carried on. Complete dispensaries for the filling of prescriptions were installed wherever required.

The foregoing remarks bear generally on the facilities which provided the necessary conditions for the furtherance of professional skill. The monotonous routine of institutional life must of necessity be broken by periods of recreation if the patient is to remain happy.

RECREATION AND VOCATIONAL BUILDINGS.

In the larger institutions constructed, recreation halls, equipped with apparatus of all kinds for mental and physical amusement, were erected. These buildings were usually of the two-storey type, the top floor being utilized for the showing of moving pictures and for use as an open gymnasium for the benefit of those whose physical condition would permit them to indulge in such pastimes. The basement, or ground floor, of the recreation hall was usually equipped with billiard tables, bowling alleys, canteens, barber shops, libraries, reading rooms, and so forth. The theatre portion of the building was so arranged, with stage and curtain, that amateur or professional theatricals could be properly staged at any time. These excellent recreation facilities had a wonderful effect on maintaining that proper degree of happiness among the patients which is so necessary to the well-being of one who is undergoing treatment.

The progressive policy of the Government in re-training disabled men for new occupations has already been discussed

in detail in a previous chapter. The activities of the Vocational Branch of the Department could not be made effective until such time as buildings were available in which to carry on academic courses and industrial re-training. In practically every city in Canada of any size, re-training classes were established on a large scale, and the work of providing accommodation for this work entailed considerable constructional activities.

In some places, vacant factories were procured, and their whole interior remodelled to suit the conditions required. In other instances where existing buildings were not available, new structures had to be designed and erected, and considerable care and forethought was expended in making these suitable in every regard for the re-training of disabled men. This work did not, of course, call for so much original thought as that required in the design of hospitals, but speedy execution of the construction of new buildings and the alteration of those acquired was necessary in order that the work might go forward as rapidly as possible.

The pulse of an institution is centred in its power-house. As already mentioned herein, a central plant was employed in supplying heat, light and power to institutions which were erected. The central power-house was not only used for the supplying of heat, but very often where local rates made the procuring of electricity prohibitive, steam generating sets were installed and the institutions supplied with power and light. Included in the power-house lay-out was usually incorporated complete machinery for refrigeration which operated all cold storage rooms throughout the institution. In large institutions, where justified, complete laundry units were erected to take care of the hospital's requirements.

The work of the hospital programme laid out may be roughly divided into two groups: first, the provision of general hospital facilities which includes accommodation for convalescent and active treatment cases; the second natural division is that relating to the provision of hospitals for the treatment of those ex-members of the forces suffering from tuberculosis.

PROVISIONS FOR CONVALESCENT, ACTIVE TREATMENT AND
TUBERCULAR CASES.

In the general hospital group, and distributed in proper relation amongst accommodation for convalescents and active treatment cases, comes the provision of accommodation for incurables, mental defectives, neurological types, and those cases requiring special treatment under special conditions.

[EDITOR'S NOTE.—The original manuscript, not given here, continues giving full description of the activities of the Government in providing hospital accommodation for convalescents, active treatments, incurables, mental defectives, neurological types, etc., etc. With very few exceptions, all hospitals included under these headings were planned and designed by the Military Hospitals Commission and its successor, the Department of Soldiers' Civil Re-Establishment, and by the end of March, 1918, some 12,000 beds were actually occupied and about 6,000 practically ready for occupancy. Due to change of Government policy, the Department of Militia and Defence took over the majority of these institutions, and the work on uncompleted institutions was carried on by the Public Works Department, who also made additions thereto and constructed some new centres as required. Descriptive matter bearing upon the general layout of these hospitals appears in another article in this book, and the original matter of this manuscript has therefore been omitted. The original manuscript, after dealing with the group of institutions giving accommodation for the cases above noted, continues in an exhaustive way to deal with the provision of sanatoria for those ex-members of the forces returning from overseas suffering from tuberculosis. Space here does not, however, permit of a reprint of all the text matter or illustrations in this connection, but the following will give a general idea of the policy which was adopted by the Department in providing sanatoria, and a portion of the manuscript given deals with a special type of pavilion for use in Western Canada. The description of this pavilion will give a general idea of the exhaustive manner in which planning was gone into.]

The policy adopted by the Department in providing sanatorium accommodation for those suffering from tuberculosis, will prove of lasting benefit to the Dominion. Canada had, in pre-war days, a string of sanatoria from coast to coast which were variously operated by Provincial Governments or independent associations.

With the arrival of patients from overseas, it was very apparent that Canada's hospital programme with reference to accommodation for those suffering from tuberculosis, would have to be a very extensive and complete one, if the cases were

to be properly cared for. Civilian sanatoria accommodation was full to overflowing, and it was impossible, therefore, to obtain admittance for the Department's patients to these institutions. At the same time, it seemed to be ill-advised for the Department to launch into a programme of erecting sanatoria throughout the length and breadth of the country, without looking toward the final use to which these institutions might be put.

The Department finally succeeded in obtaining the co-operation of those in charge of various sanatoria already established, in making extensions to existing facilities. The co-operation thus afforded was usually in the manner of a substantial contribution toward the cost of such extension, the buildings so erected to finally revert to the control of civilian institution. By this procedure, great economy in the provision of tuberculous accommodation throughout Canada was possible. In many cases, it was found possible to add considerable bed accommodation to institutions without materially increasing the general services. Such opportunities meant that the Department had the advantage of a large investment without the attendant first costs.

Always having in mind the more or less permanent nature of the sanatoria accommodation to be provided, it is possible that even more research work was done in the matter of planning these institutions than that followed in the general hospital work.

The design of accommodation for infirmary and incipient cases as finally followed by the Department, has practically revolutionized sanatoria lay-outs in Canada. From a comparison of the Canadian plans with those of other countries, it is doubtful if any of these later institutions show the same thought and care as evidenced in the designs of those prepared by the Department. Sanatoria superintendents and professional men expert in the treatment of tuberculosis, were constantly in consultation, and an endeavor was made to arrive at and incorporate the best ideas available. Some of the prominent institutions in the country to the south were visited with a view to ascertaining the best practices followed in that country.

A new type of pavilion peculiarly adapted to the rigorous climate of Western Canada has been adopted, and specialists claim that it is one of the best that has yet been attempted. Provision of adequate infirmary accommodation has also been made, and this building incorporates the newest features considered desirable for the furtherance of the treatment of cases in the advanced stages of tuberculosis.

The general services of the institution were so designed that the institution could finally take care of 500 patients. Having in view the ultimate use to which this institution would be put, namely, the care of the general public of the Province of Alberta, the lay-out of the institution was arranged to properly provide male and female accommodation. The buildings are divided into two groups—each group consisting of a number of pavilions for incipient cases, and an infirmary building providing the proper proportion of beds to take care of the advanced cases in each centre. Both groups are under the direct control of one administration building, which, in turn, is in direct communication by underground tunnels with the service buildings, the infirmaries, and the power-house.

The administration building lay-out embodies all features necessary in the business management and control of a centre of this kind, and in it are installed complete operating suites, clinics, treatment rooms, X-ray departments, and so forth, for the whole institution. This method of centralization is somewhat of a departure from the usual custom which has generally been followed in civilian institutions, it being usual to place such facilities in the infirmary. This, however, in a lay-out such as that planned for Central Alberta Sanatorium, would prove uneconomical, inasmuch as the existence of two infirmaries would necessitate the duplication of equipment and general control. The service building, which will ultimately contain two large dining-rooms, is designed to give to those patients who are well enough to walk to their meals, food by the cafeteria system. The central kitchen in this building will prepare all food for the entire institution, and food will be delivered to the infirmaries in heated food wagons through underground tunnels. The power-house to the rear is also connected with the main group of service buildings by a tunnel.

and embodies all those features necessary in a complete power-house unit. Arrangements are pending with the Canadian Pacific Railway, whose main line is in the vicinity of the institution, to run a spur to the power-house, so that coal may be delivered with the least handling possible.

WAR HOSPITALS AND CIVILIAN NEEDS.

[EDITOR'S NOTE.—The following extract from the original manuscript deals with the possibilities of following in part Canada's War Hospital Programme in providing sufficient accommodation for civilian needs.]

The carrying out of the Department's policy in reference to hospital accommodation, is perhaps one of the most extensive schemes of its kind that has ever been carried to a successful conclusion under one central organization in Canada. Its success was largely due to the farsightedness and capabilities of the late Deputy Minister of the Department, Mr. Samuel A. Armstrong. Mr. Armstrong, previous to his connection with war work for the Federal Government, was Assistant Provincial Secretary of the Provincial Government of Ontario, and during his period of office with the Province, promoted many large schemes for the hospitalization of the populace of Ontario. The Chief Architect of the Provincial Secretary's Department of Ontario, Mr. Jas. Govan, was also largely instrumental in a consulting capacity, in reference to the formulating of original schemes for Canada's war hospitals. While Mr. Govan was never actively engaged by the Department, his advice was often sought. The general merits of the work can be generally attributed to the faithful and untiring efforts of those men who were actively engaged in the work. Special mention may here be made of the untiring attention and close application paid by Mr. W. L. Symons to the work during the period that he was on the staff of the Department.

Canada's type of war hospital, as already stated herein, was evolved after most careful consideration had been given to the problem. The scheme adopted was largely on account of the necessity of keeping constructional expenditures to the absolute minimum. During the operation of the institutions, other facts have become apparent, and it has been found that

their operation and general upkeep has been maintained with just as much ease, and possibly with more economy than hospitals erected for civilian purposes during pre-war days.

When it is considered that the patient day costs in Canada's war hospitals does not surpass, and is probably less than similar costs in other institutions, and when this consideration is coupled with the fact that the capital expenditure involved approximates less than 50 per cent. of what ordinary institutions cost in pre-war days, one immediately realizes that here is an object lesson, a careful study of which may lead to solving the difficult problem of providing Canada with sufficient institutions to properly meet the needs of its population.

There is a great lack of civilian hospital accommodation in Canada at the present time, and if proper and adequate facilities are to be provided, some very progressive programme will have to be instituted.

Those who are responsible for the public welfare, while realizing the necessity of accommodation, are loath to promote constructional projects that would properly meet the situation, on account of the enormous increase in construction and material costs. Even before the war, the erection of hospitals and institutions involved expenditures that invariably raised the tax rate apparently out of all proportion to the facilities afforded. Only our larger cities seem to have been able to finance the erection of institutions that would afford the most up-to-date facilities.

One step toward solving the cost of institutional work is seen in the Community Hospital Movement. This proposal puts forth the idea of establishing central institutions which will serve a number of neighboring municipalities. It is believed that this step is one in the right direction, and if the proper degree of intermunicipal co-operation is maintained, there is no reason why such projects cannot be carried to a successful finality. To-day, with our advanced facilities for transportation, the good roads movement, and the almost universal use of motor transport, the community hospital, serving a number of municipalities, is an idea which, if carefully worked out, should give the desired results.

There is another phase of institutional work which, in these days of "monolithic" structures, seems to have been passed un-noticed by those who are most affected. Civilian hospitals erected in pre-war days have generally been of the "monolithic" or multiple storey type. Canada's war hospitals which represent an accommodation for nearly 20,000 men, have been commented upon most favorably by those in a position to criticize, as obtaining all those features of utility that go to make up an efficient working hospital. Due to the rapid advance that is continually being made in the science of medicine and surgery, the useful life of an institution is a comparatively short one. We have evidence of this at every hand, inasmuch as hospitals constructed comparatively a few years ago are now out of date; and professional men are urging the provision of more up-to-date facilities. The unit type of hospital, as followed by Canada for war purposes, would appear to more nearly meet the situation than any other possible scheme. The buildings are of cheap construction, but at the same time their interior arrangement and finish provides every facility required. Extensive constructional methods and elaborate use of bricks and mortar do not aid in the recovery of the patient. It would seem, therefore, that the logical conclusion arrived at in the solving of Canada's future hospital policy, is that designers should confine themselves to the least possible capital expenditure, so as to permit of procurable funds being readily available for the proper maintenance and professional care of the patient. Reduction in capital expenditure means reduction in hospital rates. Reduction of capital expenditure will make funds available for improved services. It will surely be conceded that money expended in providing increased numbers of medical staff and nurses, accrues directly to the benefit of the patient, whereas such money sunk into elaborate building methods is lost entirely, in so far as the well-being of the patient is concerned.

It is not to be concluded from these remarks that the erection of inflammable structures is recommended. Institutions composed of unit buildings of one-storey height, or at the most two, will permit of the lightest possible type of fireproof construction. The exact type of construction to be used is a matter de-

pendent upon too many considerations for full analysis here. Economy lies in the policy of using unit buildings to obtain the required accommodation instead of multiple storey construction.

Who can foretell what the ideal type of hospital will be in the course of the next few years? Conditions that were considered ideal a comparatively short time ago have now been discarded. It seems probable that a similar advance will be made in the future years. To keep pace with this advance, if hospitals constructed to-day are designed and erected with proper forethought, regard to capital expenditure, and the probable length of their useful life, they may, when ideas have changed, be altered, extended, or even demolished, in order to meet the ever-changing requirements. Such facility of alteration, change or renewal could not possibly occur in a monolithic structure of reinforced concrete of the multiple storey type. Such a building, after its usefulness has come to an end, must be thrown into the discard, in so far as its use for a hospital goes.

The possibilities discussed in the preceding paragraphs are being entertained by experts, both on this continent and in Europe. The tendency of thought of many is toward the semi-permanent type of construction for future institutional requirements. It would appear that Canada's experience gained in its hospitalization programme confirms, to a large extent, the soundness of these views.

Selected Articles

THE HAZELTON HOSPITAL

BY HERMAN J. FERRIER.

NESTLING among groves of birch and poplar, and surrounded by the fertile fields which contribute so much to the comfort and health of its patients, is the Hazelton Hospital, harmonizing in its every appearance with the natural beauty around it. Farther



The Hazelton Hospital

away, forming a fitting background, is the magnificent Rocher de boule Mountain, lifting its snowcapped peaks toward the sun, symbolic of the tireless energy and the abiding and lofty purpose of the man to whom the hospital owes its existence.

Nineteen years ago Dr. H. C. Wrinch arrived in Hazelton, accompanied by his devoted wife whose energy and resourcefulness were to play such an important part in the success which attends his life work. They proceeded at once to Kishpax, an

Indian village on the river of the same name, situated at the point where it joins the Skeena some ten miles above Hazelton.

It is impossible to convey to anyone who is unacquainted with the Northland just what it meant to these two people to travel from their homes in Old Ontario to the Pacific Coast and thence up the Skeena River about two hundred miles to Kishpiax, the uppermost point of navigation. More difficult to bear than the separation from kith and kin was the total absence of any congenial companions, they being almost the only white people in that part of the country. However, it was to minister to the needs of these people, physically and spiritually, that the doctor and his wife had come, as the thought uppermost in their minds was that they came to serve in the name of Jesus.

It early became apparent that there were other pressing needs besides those of the Indian population at Kishpiax. The Town of Hazelton, situated at the junction of the Bulkley and Skeena Rivers, was the strategic point which, to the statesman-like mind of the doctor, would enable him to serve the entire population then present, and, at the same time, give access to the wider fields of the Bulkley Valley and the valley of its tributary streams which, to his mind, even at that time, were to become the homes of many hundreds of settlers. In order to meet the requirements of the Provincial Medical Licensing Board, our stalwart missionary walked a distance of more than 120 miles in order that he might catch the boat to Victoria when navigation opened, and thus be able to write the examination set by that body.

On his return to Hazelton he secured the site now occupied by the hospital, and partly cleared the road to the town, a distance of a mile through the woods, in order that the lumber might be taken to the building site. He then built the house in which he now lives, and which at that time served for hospital and dwelling combined, doing much of the work himself. The moderate space thus provided was soon more than filled. The doctor and his wife were the full working staff of the hospital, Mrs. Wrinch heroically shouldering the duties of nurse and cook for the patients as well as attending to the wants of their family.

At times, the dining-room of the home had, perforce, to serve as an operating theatre, and many a life was spared for future usefulness as a result of the splendid choice made by the Methodist Missionary Society in their selection of Dr. Wrinch for this work.

It was not long before this beginning, good as it was, came far short of meeting the needs of both natives and whites who sought treatment at the hospital, thus providentially afforded them, and the doctor at once began to work out the plans which, it would seem, he always had in mind for the enlargement and perfecting of its service. With local assistance and that afforded by the Dominion and Provincial Governments, the present buildings were established. With the advent of the Grand Trunk Pacific construction work, when hundreds of men received treatment efficacious to a degree that would have been otherwise impossible, the wisdom of this step was at once apparent. It is striking testimony to the kindness and skill of Dr. Wrinch and the treatment received in the hospital that today numbers of these men, when in need of medical advice and treatment, return from many a larger centre to the Hazelton Hospital.

With the completion of the railroad and the opening up of the mining and agricultural industries, the hospital assumed a permanent place in the northern interior of British Columbia. It is the only hospital between Prince George on the east and Prince Rupert on the west, a distance of more than four hundred and fifty miles. A more practical illustration of the value of the Missionary Society's work in making possible the settling up of great tracts of virgin soil, because of the security thus afforded the settlers, would be hard to find.

At present there is accommodation for nearly forty patients, whose wellbeing is attended to by a staff of thirteen persons, including five nurses, a lady superintendent, and a resident house surgeon, who, with Dr. Wrinch as superintendent, form the medical staff of the Hazelton Hospital. The equipment is of the most modern type. There are seven private wards well furnished and comfortable, and one semi-private, all of which are practical illustrations of the ministry of those persons, scat-

tered far and near over the Dominion, who wished to do something for their Master by serving the requirements of persons in need of these things. If those who have established the various private wards could look in these rooms when patients are resting and realize the comfort thus afforded, it would be infinite return for the investment. Then there are two light and airy public wards, with sun gallery for Indians, reception ward and admitting room, operating theatre, sterilizing room and X-ray room, containing one of the most efficient and modern machines. An up-to-date electric plant not only supplies the power for the X-ray machine, but lights the entire plant, runs the laundry machinery, and pumps the water for the institution. A splendid farm and garden consisting of two hundred and sixty acres, lighten the operating expenses in these days of the high cost of living.

In addition to these many and varied tasks which give little chance for leisure, the doctor is leader—a leader, it might be truthfully said, in all movements for community betterment and patriotic purposes. Last of all, and, perhaps most important of all, is the fact that he has never forgotten that it is his high duty and privilege to hold up the light of the Gospel of Jesus to all whom he meets. Not in any ostentatious way, but in quiet, kindly, faithful service, by medical treatment, by preaching sermons, by unknown (to others) hours of toil and deeds of kindness he has faithfully endeavored to fulfil the call which led him to devote his life to the uplifting of his fellowmen as a service rendered to Christ his Leader and Guide. The Methodist Missionary Society has reason to rejoice that it has been the agent under the providence of God in establishing such an institution in this country, and especially in having opened up a pathway of service to one whose vision of his call has never grown dim with the passing of the years, and to-day is one of the most efficient physicians and up-to-date surgeons, and, over and above all, in the best and highest sense, a missionary of Jesus.—*Christian Guardian*.

INTERNESHIP AND GENERAL PRACTICE

YEARS ago, when the writer of this editorial was a medical student (from which anyone who is so inclined is at liberty to guess the editor's approximate age), it was the custom for a young man who purposed entering the medical profession to serve a preliminary apprenticeship in the office of a practising physician preparatory to beginning his course in a medical school. Indeed, in England, where the writer's early years were spent, this method of procedure was obligatory, in accordance with the requirements of the General Medical Council, which controlled the requirements of medical education. In this country it was customary to pursue a similar course.

With the lengthening of the college course, and the introduction into that course of extensive clinical features, the custom gradually died out, and the student relied upon his school curriculum alone for his preparation for practice. Still more recently, the educational nestors of the profession, recognizing the need for additional practical training, have decreed that the student, after completing his college course, and receiving his diploma, must serve an internship in a hospital before being regarded as properly "qualified" to practise medicine. A hospital internship nowadays constitutes an integral part of a first-class medical curriculum.

With the principle involved in this requirement we are heartily in accord. But whether in every case a hospital internship really carries out the principle, we may be permitted to question. If it were practicable for every such internship to be served in one of the larger municipal or state hospitals, where, as a rule, provision is made for the reception and treatment of all sorts of cases, then, indeed, an interne service might well fulfil the purpose it is intended to do. Unfortunately, however, the great majority of internships are served in private hospitals—some of them very limited institutions indeed—where the experience and training thus obtained are restricted to the particular kind of work to which the hospital happens to be devoted.

Even in the most general type of a private hospital there are certain diseases which are invariably barred from entrance;

and these, as it happens, are diseases in which there is special need that the general physician be well drilled,—notably the contagious and infectious diseases. Thus, in an internship served in a private hospital, no matter how large or how well organized the institution may be, the graduate receives absolutely no experience in the diagnosis and treatment of scarlet fever, diphtheria, measles, meningitis, or (most important of all) tuberculosis, because a private hospital will not knowingly receive such cases. Small wonder that so large a proportion of general practitioners fall short in their diagnosis of pulmonary tuberculosis, as we are so often told. And practically every newly graduated physician is obliged to learn for himself the recognition and management of contagious diseases during the first year or two of family practice.

The real truth of the matter is that in his hospital internship the graduate, as a rule, receives worth-while training in little else than surgery. In the vast majority of private hospitals the surgical service looms so enormously large, both in the activity of the institution itself and in the interest of the interne, that internal medicine, even to the extent that the hospital practises it at all, is usually scamped and neglected by the interne, unless he happens to have a special personal leaning toward that side of the profession. It must be admitted that the hospital internship requirement has turned out a set of practitioners of a much higher average, surgically, than were ever turned out before in the history of medicine. But we gravely question its efficiency in turning out better medical clinicians.

What is the remedy? We confess, we hardly know. Perhaps less medical schools, and more public hospitals, so that there may be a more adequate proportion between the two, and opportunity for all medical graduates to receive their interne training and experience in these institutions, which admit and care for patients suffering with all kinds of disease. Perhaps, the addition of a certain amount of externe, as well as interne, work in connection with the hospital service, under the supervision of competent clinicians. Perhaps some other course, still to be devised. Certainly, however, there is an important hiatus at this point which calls for the attention of those who map out the medical student's curriculum.—*Medical Standard.*

Book Reviews

Clinical Studies for Nurses—for second and third year pupil nurses. By CHARLOTTE A. AIKENS, late Director of Sibley Memorial Hospital, Washington, D.C. Fourth edition, revised and illustrated. Philadelphia and London: The W. B. Saunders Co. Canadian Agents, The J. F. Hartz Co., Limited, Toronto. Price \$3.50 net.

This work provides graded instruction for nurses who have had training in the preliminary branches—anatomy, etc. It aims to simplify and system teaching, to promote uniformity, save teachers' and pupils' time. The main points in the common diseases and their management are discussed briefly and clearly. Illustrations are used quite freely. The author in a timely foreword to nursing teachers recommends round table conferences of senior nurses, and systematic reading outside of text-books. Stress is laid on hygiene and dietetics. Newer ideas on nursing of surgical, nervous and mental cases, arising out of the Great War and added civilian experience, are presented. Every practising nurse will find this a useful book. The author states, "There is a steady decrease in bacterial diseases (even if slow)." We question this statement. The questions and answers, formulae for solutions, menus, and blank sheets for notes are other valuable features of Miss Aikens' practical and up-to-date volume.

The Psychology of Nursing. By AILEEN CLEVELAND HIGGINS (Mrs. John Archibald Sinclair, A.B., R.N.), War Relief Superintendent of the Stanford School for Nurses, San Francisco, Cal.; Instructor in War Emergency Courses, University of California. G. P. Putnam's Sons, New York and London (The Knickerbocker Press). 1921.

That a successful nurse must be a psychologist there is no question. A good nurse must, as Vincent de Paul taught, not only try to treat her patients but must understand them. She

should try and cultivate an attractive personality, know how to approach them, otherwise she cannot and will not measure up. The world-wide loved Florence Nightingale understood too the importance of the psychological side of nursing and always impressed upon her pupils the fact that good nursing included a knowledge of human behaviour. Psychology should undoubtedly be part of a nurses' curriculum. The author of this book has written along right lines, and the volume should find a ready sale.

Eating to Live Long. By WILLIAM HENRY PORTER, M.D.
With introduction by Edwin F. Bowers, M.D., Chicago.
The Reilly & Lee Co.

The author has given an alluring title to his book. Although casuists might cavil at the addition of the final word, since long living under some conditions is not always to be desired. Dr. Porter is an iconoclast; he breaks down some of our strongest food theories and practices. He writes strongly on the evils of fruit as "the head and front of all offenders" in the promotion of intestinal indigestion. All cereals, including porridge, and many vegetables, including potatoes, are excluded from his dietary list, while sweets are largely taboo. The author approves of eggs, milk, whole wheat bread, and meat in restricted quantities, as standard articles of food for an ideal diet.

Manual of Bacteriology and Pathology for Nurses, by JAY G. ROBERTS, Ph.G., M.D., Oskaloosa, Iowa. Third edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1920. Price, cloth, \$2.00 net.

This little book is a very interesting short treatise on the subjects of Bacteriology and Pathology and should prove very valuable in the hands of young women just at the outset of their professional career when they are acquiring their first practical acquaintance with disease.

The combination of the subject of Bacteriology with that of Pathology at the outset of her course should be in itself very suggestive to a nurse and each should serve to make the other subject more clear to a beginner.

Both subjects are dealt with briefly, and while something occasionally is lost in style due to this desire for brevity, yet the purpose of the book would seem to be to clear the air for the nurse at the time when everything is new and confusing.

This text should admirably fulfil that purpose, and with the more intelligent nurse, should pave the way for a thorough study of both subjects.

In fact, the book, and especially the part on Bacteriology, should be found very readable for any of the general public who are desirous of something more than the indefinite ideas with regard to disease and its treatment that are so prevalent to-day.

As a primary text this book should fill an important place.

French-English Medical Dictionary. By Alfred Gordon, A.M., M.D. (Paris). Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Price \$3.50 net.

This volume will be of especial interest to our boys who have served "over there," and to those who are willing to closely follow the progress in French medicine in the original. Each French word is accompanied by a combination of letters in English, giving the pronunciation as accurately as possible.

Materia Medica, Pharmacology and Therapeutics for Nurses. By AMY E. POPE, Graduate of the School of Nursing, Presbyterian Hospital, New York. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1921. Price, \$2.75 net.

Of recent years a great many books, dealing with the various phases of nursing, have been published; some, however,

not of any particular merit. Miss Pope has, in this volume, presented her sisters in the profession with something worth while. It is essentially practical, particularly the section devoted to the administration of drugs, their dosage, prescriptions, etc. We commend the short chapter on "How Drugs May Act as Remedies," and "What Students of Nursing Should Learn About Drugs."

Bandages and Bandaging for Nurses. By M. CORDELIA COWAN, President Colorado State Board of Nurse Examiners and Superintendent of Nurses, Longmont Hospital, Longmont, Colo. Philadelphia and London: The W. B. Saunders Co. Canadian Agents, The J. F. Hartz Co., Limited, Toronto. Price \$2.25 net.

A small handbook giving the fundamentals of bandages and bandaging. The different methods are fully illustrated, and the directions concise and clear. The book should be of value to nurses and medical students.

Eye, Ear, Nose and Throat Nursing. By A. EDWARD DAVIS, A.M., M.D., Professor of Diseases of the Eye, in the New York Post-Graduate Medical School and Hospital, and Beaman Douglass, M.D., Professor of Diseases of the Nose and Throat in the New York Post-Graduate Medical School and Hospital. Second revised edition, with 32 illustrations. Philadelphia: F. A. Davis Company, publishers. 1921. Price, \$2.50 net.

A small handbook evincing completely the title subject. A full and detailed account is given of the ordinary nursing methods and special attention given to the subjects of asepsis and antisepsis. A brief outline of the necessary anatomy and physiology is included. The book should be of great value to nurses and students, and especially to those who lack practical experience along the lines indicated.

HOSPITAL SOCIAL SERVICE

The Hospital Social Service Quarterly, after two years of publication, has become a monthly magazine to be known as *Hospital Social Service*. Medical social service in hospitals has passed the formative stage and is now recognized as a distinct department of the hospital.

The Hospital Social Service Quarterly was first published in February, 1919. Prior to this time the chief writings on the subject were embodied in the works of Dr. Richard Cabot, and in occasional special articles in hospital and medical journals. The Proceedings of the Hospital Social Service Association of New York City preceded the Quarterly and consisted chiefly of papers read at the meetings of the Association. The first issue of the monthly magazine contains the survey of hospital social work in the United States which was made by the American Hospital Association last year; an account of social work in hospitals of Toronto by Mr. Robert Mills, of the Toronto Health Department; an article by O. M. Lewis and two collaborators of the Division of Venereal Disease of the Massachusetts General Hospital; a discussion of methods of parental authority, by Miss J. L. Beard. Besides news notes and abstracts of articles of interest to the medical social worker, there are departments devoted to the American Association of Hospital Social Workers, and to cardiac, nutritional and handicap work.

HOSPITAL BY-LAW IN WOODSTOCK CARRIES

THE by-law covering the grant of \$65,000 by the City of Woodstock toward the building of an extension to the Woodstock Hospital carried on April 25th by a handsome majority. The vote was 1,028 for to 362 against. One-third of the names on the list, or some 750 votes, were required to carry the measure. The proposed addition will fulfil a much-felt want. It is to be a wing, and the cost is to be about \$100,000. The county has already granted \$20,000, and work is to be commenced shortly.

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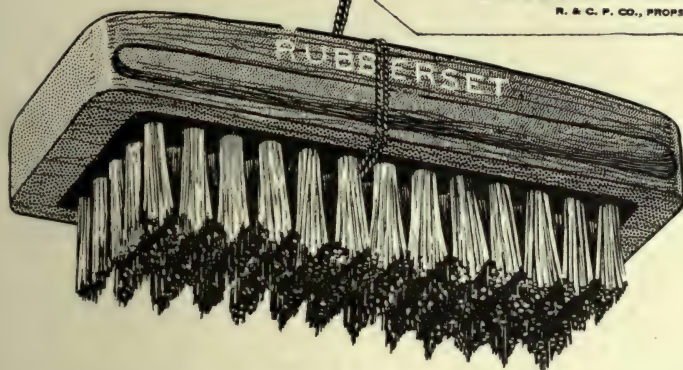
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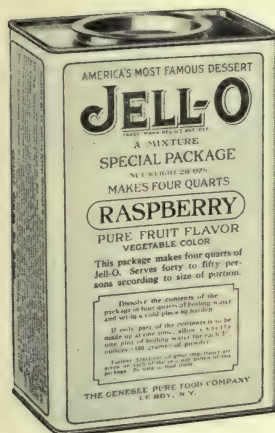
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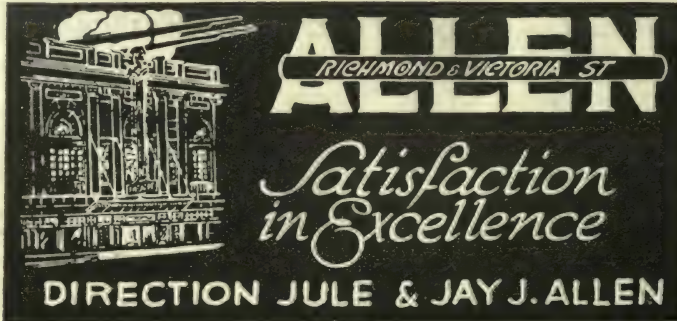
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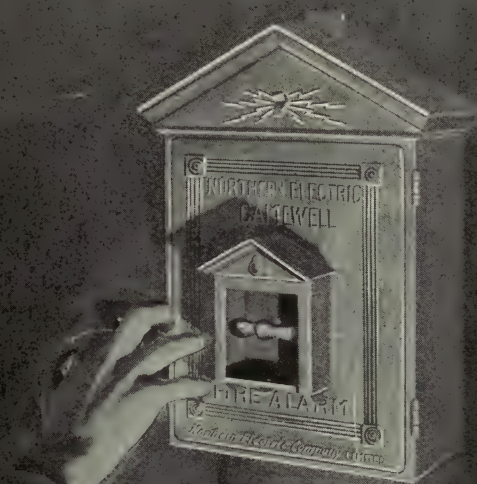
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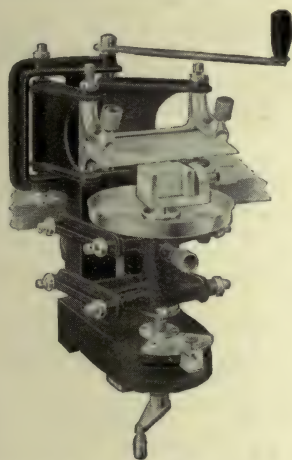
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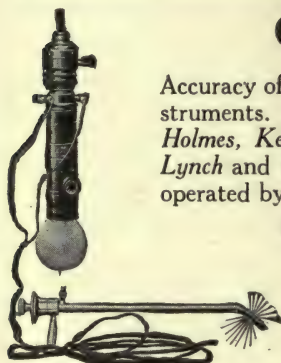
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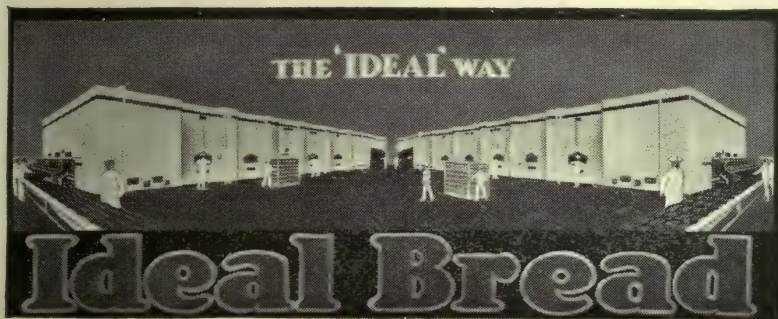
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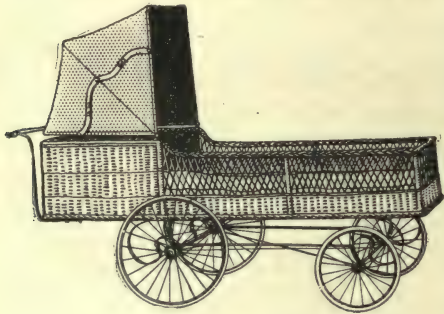
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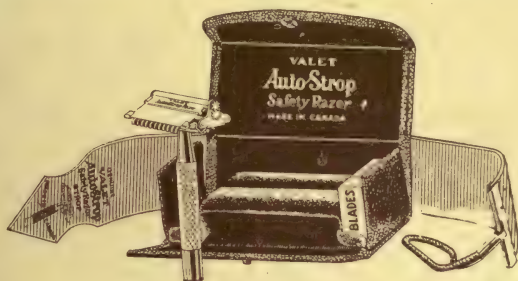
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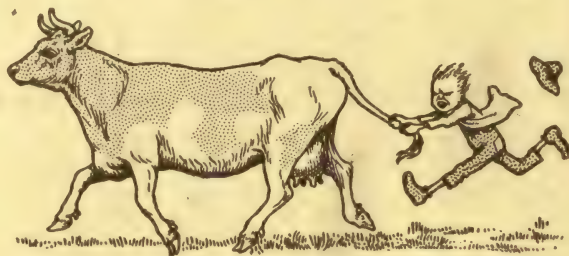
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Vol. XX

Toronto, July, 1921

No. 1

CONTENTS

EDITORIALS

	Page
Hospital Day	1
Hospitals and History Taking ...	3

ORIGINAL CONTRIBUTION

Who is Who on the Hospital Staff. By John Hunter, M.B., Toronto	6
--	---

SELECTED ARTICLES

	Page
Practical Application of Methods of Standardization to the Hos- pital. By George Gray Ward, Jr., M.D., F.A.C.S., New York.	9
The Time of My Life	21

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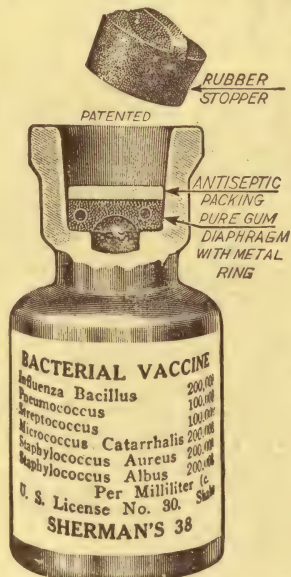
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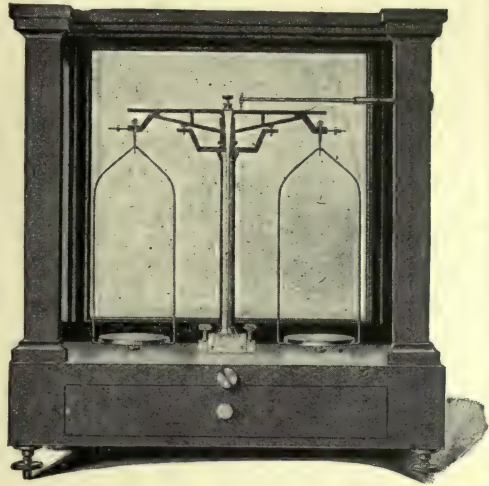
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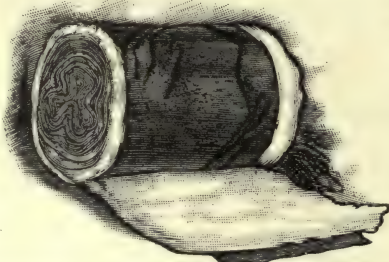
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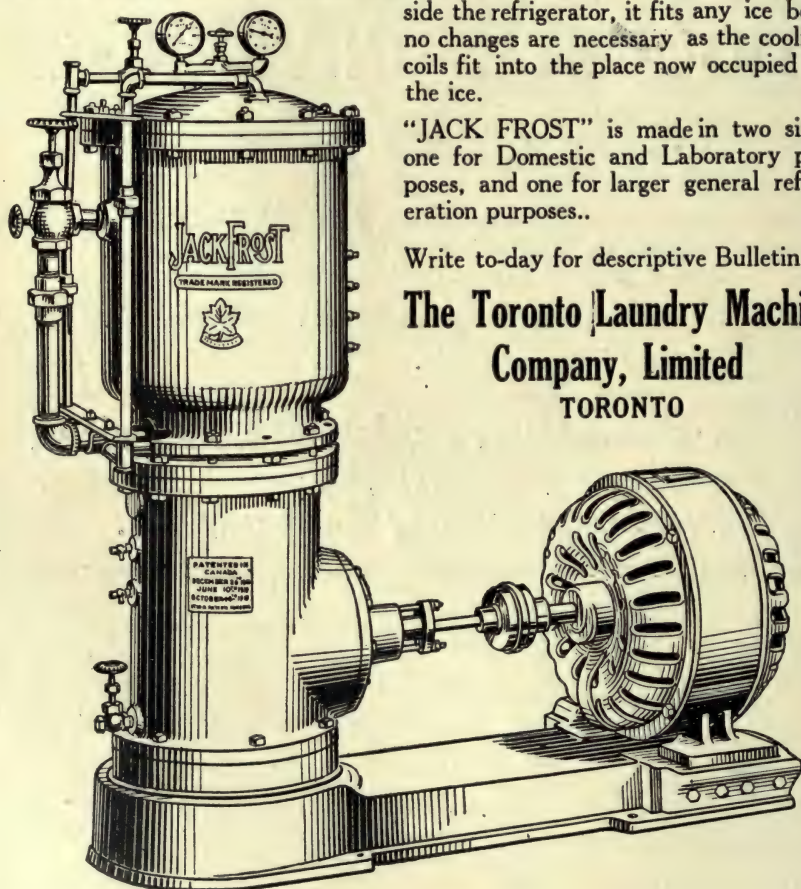
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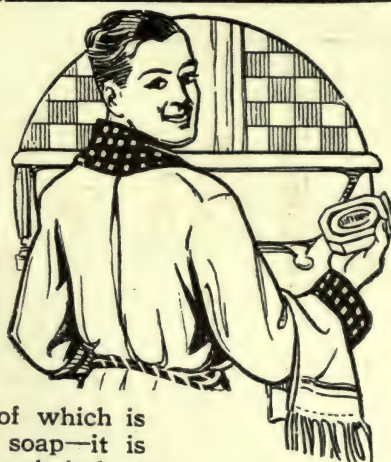
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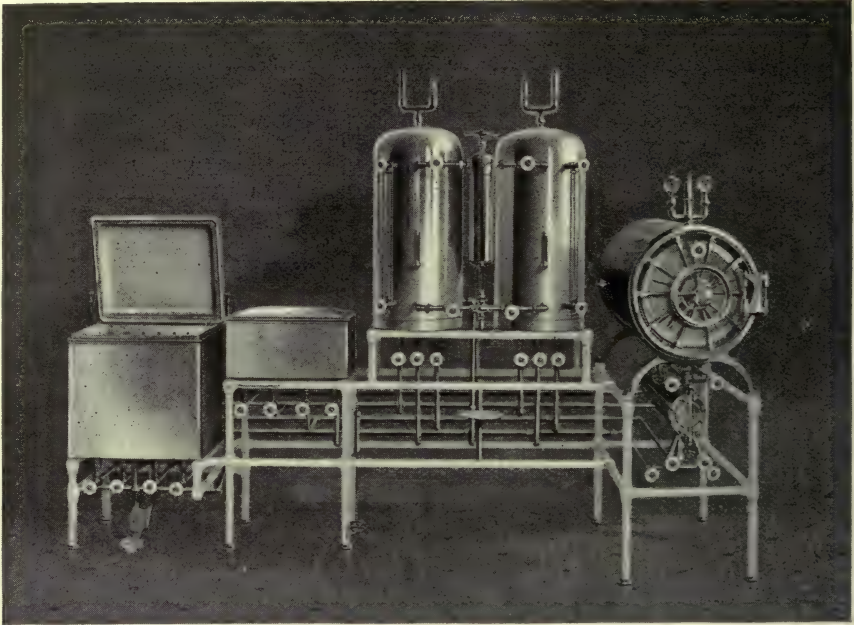
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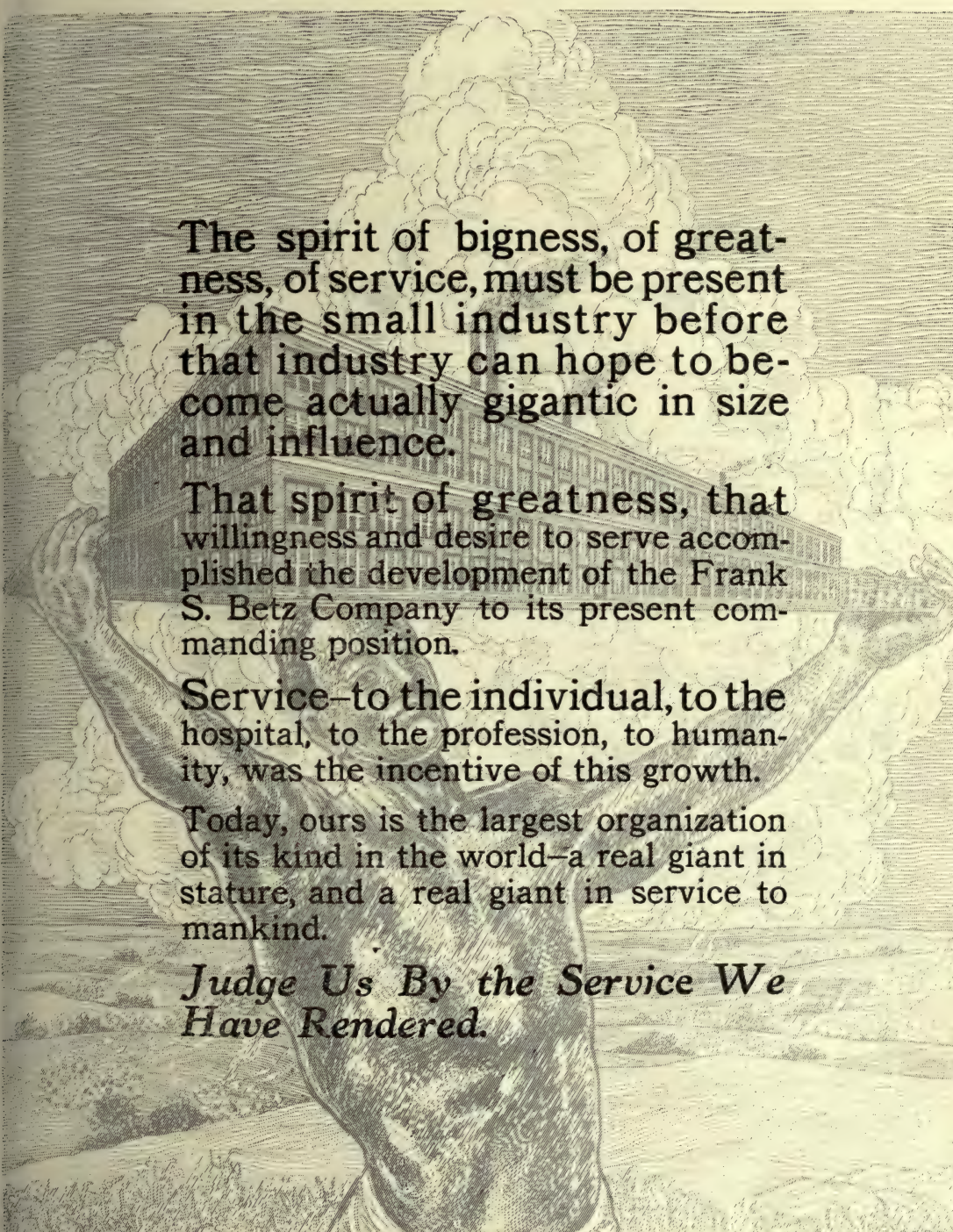
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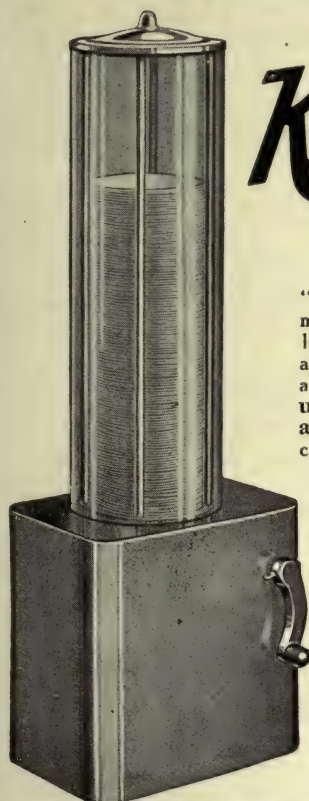
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire

Vol. XX.

TORONTO, JULY, 1921

No. 1

Editorials

HOSPITAL DAY

AS a means of attracting attention to hospitals, their work, and their needs, the first Hospital Day in America was celebrated on May 12th.

The press of the continent did a great deal in the way of free publicity for the movement, and deserves the warm thanks of all hospital authorities for the generous notices given.

Hospitals were in full dress for the occasion. Apart from the advertising aspect of the project, the fact that "all hands" "got busy" cheerfully, put on their "best bib and tucker," makes for the good of the hospital and its staff; just in the same way a man feels all the better for his bath and dress suit for dinner.

Some visitors have very sharp eyes: besides noting all the glamor and tinsel of the decorations, the

spotlessness of the operating theatre and the bed-clothing, some of them were curious enough, no doubt, to peer into the sink room, the laundry, the appliance room and the scullery; possibly examined the top of the porcelain lamp shades, the window ledges, or the cupboard tops. Were these likewise spotless? We hope so—everywhere.

The churches were kind in making announcements of the day. Quite right they should; for the hospital has largely taken over that branch of work of the early church—the healing of the sick.

The visitation to the hospitals stimulated interest in nursing. Young aspirants for this beautiful calling got a glimpse of the nurses and of what they are called upon to do,—a superficial glimpse, of course, but possibly enough to stimulate in them a desire to “train.” They may become disillusionized after accepting, but, like all other callings, the road to success is steep and rough; but it has its abundant recompenses.

This Hospital Day will doubtless become a regular day of the year, along with Christmas Day, Arbor Day, Mother’s Day, etc.

The committee having charge of this continent-wide movement and to whom much credit is due, were:—

Lewis A. Sexton, M.D., chairman, superintendent, Hartford Hospital, Hartford, Conn.

Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.

P. W. Behrens, superintendent, Toledo Hospital, Toledo, Ohio.

Pliny O. Clark, superintendent, Presbyterian Hospital of Colorado, Denver.

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Norman R. Martin, superintendent, Los Angeles County Hospital, Los Angeles, California.

C. W. Munger, M.D., superintendent, Columbia Hospital, Milwaukee, Wis.

George O'Hanlon, M.D., superintendent, Bellevue Hospital, New York.

J. E. Sampson, M.D., superintendent, Greater Community Hospital, Creston, Ia.

Mary C. Wheeler, R.N., superintendent, Illinois Training School for Nurses, Chicago.

Matthew O. Foley, managing editor of *Hospital Management*, is executive secretary, with offices at 537 South Dearborn street,

HOSPITALS AND HISTORY TAKING

A REPORT in the lay press from Victoria, B.C., states that amendments to the Medical Act aimed at checking up loose and incompetent doctors and protecting the public generally in the quality of medical attention it receives were introduced in the legislature Friday, by M. B. Jackson, K.C., as follows:

Every medical practitioner shall keep a permanent record of all diagnoses made by him and of the material facts upon which the same were made and of all treatment administered and in all cases of fatal termination of illness, while under treatment by a medical practitioner, a full, true, and correct copy of such records shall be forthwith filed with the secretary of the provincial board of health.

Under this provision records of the diagnosis and treatment of each patient can be investigated at any time. Mr. Jackson explained that examination of these records will show to what degree the doctor is competent and it will also show up all mistakes of which the public is now kept in ignorance.

This seems a strong step for a purely lay body to take, but in the interest of the public we believe it to be a wise one. All so-called standard hospitals are required to keep histories of their patients; and we think all doctors should keep at least brief summaries of their cases; and this is all the B.C. Act calls for.

This note-taking should be done voluntarily. Many men are doing so now, but they are in the minority. This subject ought to be discussed at our Medical Association meeting and standard history forms drawn up for use.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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Reprints, including Half-tones, etc., Supplied Authors at Net Cost.

Original Contribution

WHO IS WHO ON THE HOSPITAL STAFF

JOHN HUNTER, M.B., TORONTO (LATE OF LOS ANGELES).

THE attributes of "Who is Who" in social, political, industrial, and commercial life are quite clearly defined. The "social climber" has "made the grade" and reached the "society column" in the press. The political "Who is Who" must have something to his credit, either in the way of constructive legislation, of skill in leadership, or in a commanding personality. The industrial and commercial "princes" must have great "plants," and bulging bank accounts. These signs of success or of greatness are so distinctive that the names of these "fortune favored" ones appear almost automatically in the columns of "Who is Who" in national life.

The attributes of "Who is Who" on the hospital staff are also quite distinctive. These, broadly speaking, may be found in some one of three types. 1st, The moral, cultured, ethical man, inspired by high ideals, and who loves both his fellow-beings and his work. This type of "Who is Who" can be found on every hospital staff, but "oh, the pity of it," for are we not told that no hospital staff is composed exclusively of such men. 2nd, The skilful, competent, aggressive men, who, for the sake of enhancing their reputation, or acquiring riches, practise deception in medical cases, or do unnecessary operations in surgical ones. This class makes itself particularly obnoxious by adding to its other sins that of "fee-splitting." 3rd, The uncultured, unscientific, unclean, who, only too often at the sacrifice of life, or of the prolonged disability of their victims, use their position on the hospital staff to acquire a higher professional standing than they could otherwise obtain. The methods used in selecting a hospital staff are responsible for the two latter types. An appeal to his political party, lodge, or "cult" secures an appointment.

The question of "Who is Who" on the hospital staff was the title of a paper read on December 4th at a session of the Southern Surgical Association, held at Pasadena (California), that earthly paradise, where nature and climate offer to the possessors of unlimited wealth a free license to exploit their tastes, pride, and ambition. *En passant*, we were taken through the exquisitely beautiful "Busch Gartens," the name of which may make many a reader's "teeth water," as he recalls the joy experienced in quenching his thirst with a certain famous beverage. The writer of the paper, after his description of the types already referred to, set himself the task of suggesting some reforms. He called special attention to the so-called "close hospital staff." This distinctive brand was to be secured by very careful "hand-picking." A few reputable physicians and surgeons get together, "frame up a list," and hand it to the Board of Governors. All the medical and surgical work to be placed under the supervision of this staff. This proposition was discussed by representative men from all the larger cities west of the Mississippi, and from our own North-west. Many thought that such a staff might be a very desirable one, but now claimed to have had an opportunity of belonging to such an ideal staff. All seemed to feel that the "ideal hospital staff was still a post-millennial proposition. Many suggestions were offered *re* mitigating the menace to hospital work by the unscrupulous and incompetent members of the staff. First, compel all to present their legal qualifications, file reports *re* diagnosis, treatment, results, etc. The discussion ended in the conclusion that there are insuperable difficulties in the way of "framing up" an ideal hospital staff, and that we are forced to fall back on the scriptural injunction, viz., "Allow the tares to grow up with the wheat," and leave the inexorable justice of time to eliminate the unworthy, and to bury these and their unrighteous deeds in well-merited oblivion, while "old Father Time" gathers into his "garner," and sacredly preserves the works of such as a Lister, or an Osler, in libraries and in traditions to enrich and ennoble the lives of on-coming generations.

Pessimism is never a pleasing feature in any discussion, for after all, the work of a hospital staff is neither better nor

worse than that of other organizations—religious, civic or political, and is it not true that there was a degenerate amongst the twelve apostles, although the selection was made by the Great Physician Himself? Splendid work has been, and is being done in all our hospitals. An inestimable amount of suffering has been relieved, and the science and the art of medicine raised to a very high position. The ideal staff, if ever evolved, will be the product of good heredity, of homes where the Christian virtues are inculcated by precept, example, love, and authority, and where hard, honest toil has not been supplanted by the effeminate indulgence riches can provide; of efficient schools, colleges, and universities, for a liberal education should be an essential “passport” into medicine. Finally the hospital staff should be recruits from standardized medical colleges, which provide post-graduate courses where, after a number of years spent in general practice, or in hospital work, an applicant could obtain the rank of a specialist, and later that of a professor which would qualify him for a position on the ideal staff and to be a genuine “Who is Who” in medicine.

Selected Articles

PRACTICAL APPLICATION OF METHODS OF STANDARDIZATION TO THE HOSPITAL*

BY GEORGE GRAY WARD, Jr., M.D., F.A.C.S., New York.

Chief Surgeon, Woman's Hospital in the State of New York, and Professor of Gynecology, Cornell University Medical College.

It is a healthy sign that there has recently been an awakening of the medical profession and of those interested in hospital economics to the fact that in general our hospitals have not been properly fulfilling their functions in so far as efficiency and conservation of energy are concerned. One of the most important pieces of constructive work that has yet been undertaken by the American College of Surgeons, perhaps its most important work, has been its systematic effort to improve the existing conditions in our hospitals. For lack of a better name this work has been called hospital standardization. In 1913 the regents of the American College of Surgeons first announced their purpose of taking measures to bring about hospital standardization, and in October, 1917, the first conference of the International and State Committees on Standards was held in Chicago for the purpose of organizing the movement. At that conference the chief points brought out were:

That the proper care of the patient was held as the test of efficiency in the standardization programme; that the hospital is primarily for the patient, for his convalescence and complete recovery from illness; that there was a great need of closer co-operation between hospital staffs and hospital trustees, and that it was necessary to establish a strong administrative authority in order to accomplish results. They appointed a committee to make a survey of the hospitals of the country and to establish a minimum standard of efficiency as a basis for standardization. At the recent meeting of the college in New York city, one

* Read by invitation before the Baltimore City Medical Society, December 5th, 1919.

day of the programme was devoted to this subject, and the results of this survey and the progress made were presented. The interest displayed and the appreciation of the work accomplished were most gratifying to those concerned, and the meeting will undoubtedly act as a stimulus to the profession to improve hospital efficiency.

The programme of hospital standardization of the American College of Surgeons is a broad one. According to their bulletin it advocates no hospital pattern as the perfect pattern. It assumes no authority to gauge perfection. It assembles facts and endeavors to relate these facts to the character of service received by patients in hospitals. It aims to set free the processes of growth and to facilitate them; to bring actual hospital conditions as they exist to-day before trustees as well as the medical profession and all who have to do with hospitals, in order that they may appreciate the great need for improvement. It is the duty of the profession to educate the trustees as to their responsibilities, and when we can show them that efficiency in the hospital, just as efficiency in the factory, is an economic problem they will become interested. The statement that every cured and satisfied patient leaving the hospital is an asset, and every unimproved or dissatisfied patient a liability is just as true in the medical world as its counterpart is in the business world.

All hospitals in a broad sense are public institutions and as such are accountable to the public for the character of the work they do. Hospital trustees stand in the same relation to a hospital as trustees do to a trust fund, and the men who accept positions on the governing board of a hospital should realize that they accept a public trust and they should demand and see that they get efficient results for the money they expend. Hospital governors, as a rule, do not give the same intensive study to their hospital problems that they do to their individual business. They are interested principally in the balance sheet and do not concern themselves as to whether the results of the treatment the patients receive are what they should be. They presume that they are, but they do not know the actual facts.

The trustees are primarily responsible for the kind of care

and treatment that the patient receives, and they should not lose sight of the fact that the hospital which most successfully fulfills its function is the one which is conducted with the primary ideal of procuring for the patient the best professional care and not from the business viewpoint of financial surplus. It should not be forgotten that the character of the medical staff determines the product of the hospital and that the trustees determine the type of the staff.

There are three cardinal functions of the hospital. The first and foremost is the care and the cure of the patient. The second is educational, teaching nurses, students, interns, and the medical profession. The third is contribution to knowledge by scientific research. In order to produce a maximum of efficiency in the functions of the hospital, it is necessary for us to study the methods of systematization and standardization as employed by the efficiency engineer in the business and industrial world. The fundamental idea in efficiency is avoidance of waste. A hospital should perform its functions with a minimum waste of time, material, money and opportunity. The basic principle in the organization of any large plant, whether industrial or a hospital, is its unification with a central control in order that there may be a complete co-ordination of all departments with proper team work of the staff. This necessitates a permanent directing head with the necessary powers to insure a proper development of system and standardization. Only in this way can questions of authority and prerogative be eliminated.

It is obvious that in order to promote efficiency, the actual results accomplished by each surgeon or physician in the care and treatment of the cases placed in his charge must be made public and available for study, thus the absolute necessity of a production sheet for the hospital as for the industrial plant. This necessitates that there shall be a staff organization with stated meetings at which a careful study and analysis of the work accomplished by each department shall be made, and that reports should be presented to the trustees in order that they may know what sort of product their hospital is producing, and whether they are getting an adequate return for the funds which they are expending in the interest of its benefactors and the public.

The time is not far distant when the trustees of a hospital will not be able to ask for public support without giving assurance to the people of the community that the product of that hospital is what it should be.

In order to establish such a basis of knowledge of the hospital product, the College of Surgeons has established a minimum standard so that the trustees may be in the position to say that their hospital is complying with the requirements considered necessary by the College of Surgeons, and that they have the facts, not surmises, as to the clinical successes and failures in the hospital on which they rest their claim for support. It is as follows:

1. That physicians and surgeons privileged to practise in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is open or closed; nor need it affect the various existing types of staff organization.

2. That membership upon the staff be restricted to physicians and surgeons who are: a, competent in their respective fields, and, b, worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules specifically provide; a, That staff meetings be held at least once each month (in large hospitals the departments may choose to meet separately); b, that the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients (free and pay), to be the basis for such review and analysis.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes the personal history; the clinical examination with clinical, pathological and x-ray findings when indicated; the working diagnosis, the treatment, medical and surgical; the

medical progress; the condition on discharge, with final diagnosis, and in case of death, the autopsy findings when they are available.

5. That clinical laboratory facilities be available for study, diagnosis, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic and fluoroscopic service in charge of trained technicians.

This minimum standard is beyond all question essential to high class service to the sick and injured in our hospitals. And I may add that I believe that this standard should also require that the staff of the hospital shall recognize as a duty their obligation to contribute to knowledge by scientific research in order that their institution may fulfil its important educational function with resultant benefit to the community. Every hospital, whether connected with a medical school or not, has this duty to perform, as it is a mine containing hidden treasures of scientific fact awaiting discovery by the patient investigator. The obligation to humanity is obvious.

The problems of hospital standardization for the large or the small hospital, for the general or the special hospital are the same, although the details of application must necessarily be different. In the small or special hospital the details should be more simple and less complicated than in the large general hospital. In large hospitals the various departments may choose to meet separately. In most general hospitals it would appear wise that there should be a separate director or chief for the surgical and medical divisions of the service and possibly also of the special departments. My experience in this problem of standardization has been confined to a special hospital.

With your indulgence I shall give you some of the details of my work of re-organization, as I feel that by so doing I can best show you how I have attempted to apply the principles of hospital standardization in the Woman's Hospital.

In January, 1918, the Board of Governors of the Woman's Hospital, in the State of New York, appreciating the importance of this movement of hospital standardization, provided for a re-organization of the service. To accomplish this end, they declared for a system of unification with a chief surgeon with

ample powers, in order that there should be a standardization and simplification of procedure throughout the hospital in all departments with a centralization of responsibility. In February, 1918, the speaker took charge as chief surgeon and immediately undertook the re-organization which is now in effect. The hospital has over 250 beds, one-fourth of which are reserved for obstetrical cases. The former organization was a multiple one, there being five gynecological services and one obstetrical, and at one time there were as many as six gynecological services, the head of each being practically independent and having the power of nominating his assistants in the hospital and outpatient department. Naturally, the staff was much too large for the size of the service, every member of which had his own ideas in the pre-operative and post-operative care of his patients, and the nurses were attempting the impossible in endeavoring to carry out without error the many different sets of standing orders on file in the wards.

The administrative control of the service rested with the surgical board, which consisted of ten members, each with one vote. No organized teaching was done in the hospital. An analysis of the old order of organization showed that the hospital could not carry out its functions with a maximum of efficiency and a minimum waste on account of a divided authority, too large a staff, a multiplicity of independent services, failure properly to study end results, and lack of the stimulus of teaching. The re-organization has been planned to endeavor to fulfill the three cardinal functions of the hospital previously mentioned.

The present organization consists of but one service which is continuous and under the control of the chief surgeon. This service is subdivided into the gynecological, obstetrical and outpatient departments, and the special departments of pathology, urology, gastroenterology and radiotherapy. An historical department under an historian who has charge of the records, and the followup and social service systems completes the organization. The attending staff now consists of the chief and four attending surgeons on duty, one of whom is the obstetric surgeon, and five junior attending surgeons. Each of the special

departments has a head with the necessary assistants. The entire staff is subordinate to the chief surgeon who has the power of making all nominations in all departments. He has the assignment of all clinical material as he thinks best and he may use the same for teaching purposes.

The gynecological department has 106 ward beds and is divided into four divisions, each under the care of the chief and three attending surgeons. A junior attending surgeon is detailed for work in each division. All gynecological patients who enter the wards of the hospital from the out-patient department, or by reference, are assigned to the divisions in rotation for diagnostic study, and a report of the provisional diagnosis must be sent to the chief's office as soon as possible and not later than forty-eight hours. The cases are then re-assigned to the staff for operation or treatment in accordance with their particular interest if deemed advisable.

The obstetrical department has twenty-five ward beds and is under the care of the obstetrical member of the staff with a junior attending surgeon to assist. The out-patient department is under the supervision of one of the junior attending surgeons, who is responsible to the chief for the proper conduct of the department. There are six clinics, each having two sessions a week, so that there is a morning and afternoon clinic each day. The chiefs of each clinic, who have the title of adjunct assistant surgeon, have the necessary assistants. During the summer months when the junior attending staff act as attending surgeons, these adjunct assistants come into the hospital as acting junior attendings, and thus have an opportunity to develop and show their worth in the operating rooms and in the wards. The special departments of urology, gastroenterology, and radiotherapy, each hold two clinics a week, during which they make the necessary studies of the cases referred from the wards or the out-patient department.

The house staff has been re-organized to conform to the new conditions and to provide a well balanced service, insuring each intern work in every department. There is a paid resident gynecologist who is in charge of the entire intern staff and who is held responsible for their discipline and work. He is in

charge of all private patients and assists with these cases. The obstetrical service is also in care of a paid resident. The service of the paid residents is indeterminate and may continue as long as their work is satisfactory. The intern staff proper comprises two divisions, each consisting of a house surgeon with a senior and junior assistant. Their service is for one year and they serve in each position for four months. Each junior assistant serves two months in the obstetrical department, as we believe a man will be better prepared for gynecological work if he has special obstetrical training. The two divisions exchange services every two months so that each intern is given the opportunity to work with all the attending staff.

One of the requirements that has been instituted is that a thorough, careful, and complete pre-operative study must be made of every patient. In order to allow this, the average stay of a patient in the wards before operation is from three to four days. In addition to the history and complete physical examination, a blood examination (including a Wassermann test), blood pressure, smears, and urine analysis must be made and recorded, and if indicated, the patient must be referred to the special clinics for further study. Consultations must be held when necessary, and the consulting staff is expected to be an active and not an honorary one.

The attending surgeons have two operative clinics each during the week and they have two operating rooms at their disposal. Each attending surgeon has a followup clinic every week, which he must attend in person. Codman's end result card is used and a stenographer is in attendance. Uniform rules for the revisits and for the duration of observation of the various types of cases are in force.

A staff conference is held once a week throughout nine months of the year, at which the entire hospital staff is expected to attend. These conferences last about one hour and the medical public is welcome. The order of procedure is as follows:

Presentation by the pathologists of the pathological material of interest which has been obtained during the week; the gross and microscopical specimens are demonstrated and brief talks on the pathology are given.

The casualties of the service are next called for. Each attending surgeon must report any deaths, infections, or complications occurring during the week in patients under his care, and an endeavor is made to locate the cause. The details as shown by the case histories, and the testimony of those concerned are carefully analyzed in order that it may be determined as far as possible, whether the fault lay with the doctor, the patient, the disease, or the hospital organization or equipment.

A report on the analysis of the followup clinic of one of the attending surgeons is next made. Each of the four attendings have such a clinic once a week which they must attend in person, and once in four weeks they are required to make an analysis of the results of the cases they have seen since their previous report. This analysis must show the total number of cases seen in the clinic and the number of those which have been previously reported. The remainder which are to be reported are classified according to the results as successful, partially successful, and failures. The acid test for the determination of the results is whether the patient has been relieved of the symptom for which she sought relief, and not whether the operative result is satisfactory to the surgeon. The successful cases are disregarded, while partially successful cases and failures must be analyzed in detail and the reason given for the classification. A free discussion is encouraged in order that the operating surgeon may have every opportunity to defend his position. Cases that may have been previously reported as successful which may later become partially successful or failures, must be subsequently reported again with their revised classification.

Next a report of some case of special interest is made by one of the attending surgeons in turn; thus, an opportunity is given to present case histories or to show patients which have had successful results. Frequently a case presenting difficulties in diagnosis or treatment is shown and the advice of the conference is sought. Once each month the junior attending surgeons are required in turn to give a brief summary of the recent gynecological and obstetrical literature, or to give a

report on any hospital or operative clinic they may visit. Problems relating to technic, operating rooms, sterilizing rooms, wards, and other hospital matters are brought forward for general discussion when necessary, in order that the various points of view may be obtained. A stenographer is present during the conference who makes a complete stenographic report of the proceedings, which are kept on file in the office of the chief surgeon for further study.

During the last six months' period the data taken from the clinical records of the gynecological department and brought before the staff for review as disclosed in the monthly followup analyses which are required of each attending, showed that a total of 1,166 cases were reported. Five hundred and thirty-two of these had been previously presented to the conference and classified. Of the remaining 634 cases, four were nonoperative, and twenty-four were patients treated by radium for malignancy and undetermined as to the result, leaving 606 operative cases. Four hundred and eighty-seven of these were classified as successful in relieving the patients of symptoms for which relief was sought, ninety-seven as partially successful, and twenty-two as failures. Therefore, the percentage in our operative cases were as follows: Successful, eighty and one-third per cent.; partially successful, sixteen per cent.; failures, three and two-thirds per cent.

In a period of nine months, in 1,388 operations in both clean and pus cases, sixty-three had infections in the operative wounds. In other words, we obtained ninety-five and a half per cent. of primary union in the healing of wounds in all cases. The mortality for all cases in 1918 was one and nine-tenths per cent., and in 1919 the same. As an example of the effect of the re-organization on the followup clinic the percentage of returns has increased over 100 per cent.

I think I may say that it is the unanimous opinion of the staff that these conferences are of inestimable value and profit to all concerned and there can be no question that they have produced a marked effect in improving the pre-operative and post-operative study of our patients, with the inevitable benefit to them. No man on the staff can afford to have careless work

shown up in the strong light of the publicity and criticism of such conferences, and no man can object to a system which applies with equal force to every operator in the hospital. The interest in the meetings by the staff is very great.

I wish to call attention to a wrong impression that I fear prevails in some quarters, judging from remarks I have heard, as to the real meaning and object of these staff conferences. I am quite sure that some of our confreres have the idea that they are but still another form of the usual medical society meeting for the purpose of promoting good fellowship and of having a pleasurable discussion of medical problems. Instead, it is a duty that is an essential part of the service of the hospital and a serious accounting of one's responsibilities, and is very often much more like the confessional than a social gathering. This does not mean that the social side and the promotion of good fellowship should be ignored, but that the conferences are just as vital a part of the hospital duties as is the auditing of the treasurer's accounts.

All the staff, both seniors and juniors in every department, are expected to make some study as a contribution to the literature during the year. If any particular type of case is desired by any of the staff for the purpose of clinical research, all that is necessary is for him to state his desire and object and such cases will be assigned to him in quantity sufficient for his purpose, but he must present his results for publication in the *Annual Surgical Report of the Hospital* which is made up of these scientific contributions. To facilitate this important work we have established a library in the hospital with the latest editions of the standard textbooks and the periodicals on gynecology and obstetrics, through the generosity of the Board of Governors, and they have also provided the services of a medical artist.

The surgical report for 1918, recently published, contains twenty monographs contributed by the staff, and three theses by undergraduate fourth year students of the Cornell University Medical College as part of their work at the hospital. Among the clinical research problems studied during the year from the hospital records published in this report, are studies on

uterine curettage, ectopic gestation, uterine fibroids, salpingectomy, post-operative urinary retention, the relation of appendicitis to annexal disease, and post-operative vomiting.

One of the most difficult problems of the nursing department of a hospital with a large attending staff, is the proper carrying out of the numerous and varied pre-operative and post-operative standing orders. These orders, which are kept on file in the wards, are usually compiled without any thought as to whether they conflict with the meal hours or other essential schedule routine ward work. Their multiplicity and variance are so confusing as to greatly increase the chance of error, and with the constant rotation of pupil nurses can never be satisfactorily enforced. The ideal plan is to have but one set of standardized orders which are as simple as is consistent with common sense, and which are adjusted to the time schedule of the ward routine. One set of orders means a saving of time and energy for the nurses and interns and reduces the chance of error to a minimum, with resulting benefit to the patients and economy to the hospital. They also greatly facilitate teaching. We have compiled and put in practice in the gynecological wards such a set of standardized orders, and after a thorough trial they have proved most satisfactory. We have also prepared a set of orders for use in the recovery ward. Simplicity and clearness were the objects aimed at in their compilation, and the judgment of the head nurses in charge of the wards was the guide as to their practicability in the endeavor to make them as fool proof as possible. The technic of the operating rooms has also been standardized.

While the work of re-organization has been an arduous and difficult one, I appreciate that my task has been made possible by the fact that I have been given full administrative control. I do not believe that it would have been possible otherwise. Therein lies the reason why the problem is simpler for the special or small hospital. The large general hospital, on account of the numerous departments and the consequently large staff, has a more difficult task in working out the details. Whatever the class of hospital I consider a directing head with ample authority is a *sine qua non*, at least for each department.

In my opinion, the trustees, if they are satisfied with their staff, should ask them to select one of their number who shall have such authority for a sufficient period of time to accomplish results, and if they cannot agree, or their selection does not prove satisfactory, the trustees themselves should make the selection of a directing head from among the staff, or elsewhere, in order that they may fulfil their obligations.

We know that the successful effort of the Carnegie Foundation to raise the standard of medical education in our schools and colleges was by means of publicity. Publicity is necessary to accomplish equally successful results in hospital standardization.

As soon as the trustees of our hospitals and the public at large appreciate that at present they have no accurate knowledge of the character of the work being done, and that they cannot have such knowledge unless a systematic study of end results is carried out on the lines followed in large industrial plants where the production sheet shows facts, not suppositions, they will demand such a public accounting, and if it falls short of what they have a right to expect of the hospital and its staff, they will insist upon the necessary re-organization to make that institution efficient.—*New York Medical Journal*.

THE TIME OF MY LIFE

BY OLD TIMER.

I'VE just had the time of my life.

It was an unexpected time, crowded with unanticipated incidents, chiefly because they had an original setting under unplanned circumstances.

Therefore, this ten-day part of my life span, which is here set down in print, constituted the time of the aforesaid life—up to now.

To put the whole yarn in a paragraph, so that you'll not need to read any further, my wife and I started out for a bit of a

holiday, two hundred miles from home, and found ourselves at and in a modern Sanitarium instead of a quiet-hotel-with-all-the-comforts-of-home—as advertised!

Instead of a hostelry with bright-buttoned bell-hops, jaunty maidservants, obsequious attendants, after-dinner dances, meals set to music and a procession of motorists wildly swinging around the half-circle approach to the pillared front door; instead of all these, we landed at a sulphur-springy, bath-chairy and dietary institution where as fairly well people, we had really no business to be.

But we stuck it out and so had the time of our happy unified lives. Each asked the other, almost in the same breath, as we discovered the real nature of our rendezvous: "Are you game?" and game we both were.

Here follow, in natural sequence, some of the details; some, mark you; all would fill a Sunday supplement or flow over into your advertising space.

Hustled off the through express at the little way-station that halts its mad rush as a matter of courtesy, the motor-bus swallowed us up and whisked us townward with a speed out of all keeping with the somnolence of the village. The first object to be sorted out and fixed by the eye, after negotiating the first turn in the road, was a cemetery!

"That's a cheerful introduction!" 'cutely remarked my game partner. Evidently this health-resort burg is not like the English sea-side town which is so healthy that you have to leave the parish in order to die! "Look the other way," was my wise suggestion. I'm strong on the ostrich-like philosophy of turning a Nelsonian blind eye on any disconcerting sight. Looking the other way, what do you think we saw in the farther distance, but another colony of the departed, the white shafts gleaming brightly from a hilltop. The only possible inference was the age-long one that Death is always with us, despite mineral waters, electric baths and body massages. They may be present postponers, but they are not ultimate preventers.

Next: a series of signs, at street intersections—"Hospital zone." "Drive slowly and quietly." "No parking of cars here." Next to this a procession of wheel chairs, holding

muffled figures, and another procession of foot passengers lining up at a bubbling tap for a drink of ill-smelling and iller-tasting water.

Assignment to Room 426 followed. Chasing the porter-guide down a long corridor, I hardly took in the significance of the variety of placards, chiefly admonishing quiet. The door next to ours bore a card: "No admission except by permission of head nurse."

We are now in our room, in the proper order of happenings. The male of the race did what he always does in a new hotel room—threw himself down on the bed, travel-tired, and also to test the springs, while wife apportioned certain wearing apparel to certain hooks and holders. Thus I must have dozed off for I failed to hear a rap on the door, and the entrance of a little lady who slipped a temperature tube under my tongue. Looking up in surprise, my coadjutor carried one too!

"New patients?" softly spoke the demure nurse. "Patients!" I tried to explode, but stuttered instead, fearing to bite the fragile tube into glass mince-meat, as you do when your dentist, thrusting his hand, his infernal machine and his looking glass into your mouth, coolly asks a fool question.

The looks exchanged between the loving man-and-wife couple were strikingly though quietly eloquent. When speech was possible, I gurgled "Are you still game?" which she was.

Every hour of the day brought new developments and experiences. I first sorted out the head-nurse from the rank-and-file ones, and they from their juniors, and they from the private nurses. The woods—I mean the wards—were full of them, going about as noiselessly as the reputed Indian on a forest trail.

I've always found nurses interesting as studies in skirted humanity; in fact, I deliberately made up to some samples, from purely selfish reasons. For example, it resulted in securing a mid-afternoon cup of cocoa, and another (from the night staff) as a night-cap. My winning ways did the trick.

Later on, the lady of the combination being called home, I was left helpless and alone for a few days—except for the kindly ministrations of the white-capped sisters. I made such pro-

gress as to be permitted to smash all the displayed regulations by "resting" in the head nurse's office at 10 p.m. while she brewed the cocoa on the little electric heater.

During this same period of single lonesomeness, I tried out an experiment with the nurse who took the daily temperature of her "patient." No sooner had my spouse left on the 5.20 than one of my suspender buttons ceased to suspend. When Nurse came in, I remarked—note the tactful approach to the subject—"What would happen if I were to ask you-to-sew-on-a-button?" A temporary scare came over me at the unusualness and audacity of the request, indeed I was not sure if it were quite proper! But Nurse, equal to the occasion, as their training demands, replied "Ask me, and see."

Now I regard that as 'cute too. So I asked—and in a few moments saw her ladyship, in blue uniform and white cap and apron, seated in *my* rocking chair, in my room, sewing and smiling and chatting too, quite in a mothering fashion. It is remarkable how sewing, in a rocking chair, creates a homey atmosphere that in turn lends to nice, homey, old-fashioned talk. It was marred for only a brief moment by recalling a scene in the movies a night or two before. Supposing—supposing—she (the wife), were to return unexpectedly and rushing in—as often happens in the movie world of reality—see her man chatting to a nurse while she (the nurse) sewed on one of His suspender buttons! For the love of peace, drop the curtain on such an imaginative hap, or mishap.

But I'm ahead of my story on a proper time-table basis. Pushing the hour hand back some twenty-four, we—husband and wife now, I mean,—were taken in hand by the authorities. Our respective life histories were relentlessly set down on paper in reply to 346 questions. It beat any insurance examination ever held. The whole condition of me and my family was laid bare, making an awful record of toothaches, lumbago, milk-maid's knees and torpid livers. I came out of it feeling like the patent medicine almanac we swore by in the old homestead days. This process was what might be colloquially termed, the once over—and *once* is enough for guest or patient!

Then ensued a series of prescribed treatments. In this I ran my own show, with my own staff of doctors, nurses, mas-

seuses and electricians. What my loving partner went through at the same time, but under separate conditions, I must leave her to tell and that she avers she never will. Man-like, I'm willing to tell everything.

Now behold this hotel guest, as he thought he was, done over every lawful day as a patient. The fun part of our holiday outing was becoming increasingly gay. I had enough distilled lightning pumped, needled, brushed and drilled into me to run a motor or light a mansion. I had daily salt and pepper rubs, or was it salt only? I'm fully qualified as salt-cured, and therefore warranted to keep—fresh.

Then they developed an extraordinary curiosity about my blood and I was led into an inner cubicle from which one couldn't escape, where nurse No. 68 ran gentle little needles into my finger tips, producing lovely globes of bright red fluid which was analyzed and scrutinized, weighed and measured, put under a microscope and mayhap at the off-end of a telescope for aught I know. Finally the flow from a freshly-tapped vein was directed into a phial, to be preserved, I take it, in the Sanitarium laboratory, as a fine specimen of the real life-giving liquid.

Not content with this performance, some highly-colored fluid was injected into my arm, with the same kind of a subtly penetrating needle, until I began to feel as full of holes as the colander Mother used in the old farm kitchen, and was mortally afraid of catching cold from the draughts through these apertures.

The fun of my life? Can't you now realize the truth of the heading? But the half has not been told and never will, with the present shortage of paper and the high cost of printing.

There were the baths yet to come. The chap who locked me in a cabinet, with a hundred incandescent lights revealing every joint and bone and nail in my human framework, was alone worth the week's bill. He had every loquacious barber on the continent beaten for ready speech, caustic comments and final rulings on religion, politics, commerce and the village notables. He was no respecter of persons, in truth how can any one respect a person who, clothed only in a white sheet, is shut in a highly illuminated tub with only his head showing, and that

head swathed in a wet towel? Now I leave it to you, editor, proofreader, or other reader, would you impress your fellow beings under such circumstances? I never saw anything so funny in my humorous life as a row of us "patients," exhibited with heads only and with the enormous bodies indicated by the bulky cabinets. While viewing my towel-encased compatriots, I was seized with a queer fancy,—what a striking sight it would be if the cabinets were on rollers and we all went spinning down Main Street!

After being cooked to a turn, we were in turn helped out of the superheated, electrical chairs and led to the room-of-the-marble-slab hard by, where a shampoo was extended from the head, where it usually centres, to every point of the body compass, followed by the essence of Nirvana—what the poets call the *dolce far niente* of a luxurious existence, a pipe-dream of relaxed lassitude, as we cooled off in the "morgue" as my next couch neighbor termed the enclosure.

The application of electricity, as a matter of fact, occupied a large part of one's time-table. The way a gentle but elderly sister played checkers in the locality of my spine, with an electrically-charged glass bulb, made me feel as if I were a lightning rod. But the most dramatic experience of all was in the X-ray room where, again, a clever daughter of Eve handled the dangerously high voltage machinery as an experienced horseman controls a team that wants to run away. It was an uncanny chamber, with its hissing, sputtering wires, its suffusion of deafening sound and its spooky green light.

Then to be stood up to the harnessed monster creates a feeling suggestive of a martyr at a stake, though, perhaps, under lower temperature conditions. Casting my eyes downward in the strange half-light of the lethal chamber, my eyes were fascinated with the sight of a bald head, belonging to a doctor, who was calmly watching my wheels go round. The green light suffused his scholarly dome and touched the upper tips of his twin ears with ghostly mistiness, but the knowledge that he was seeing both into and through my upper works created a profound impression—of mysticism and helplessness. Surely this was the climax of a hotel's attention to a "guest," as I still tried to persuade myself I was.

I was offered "hot air treatment." Was it a compliment or a criticism? Was it here that some of our national and local spellbinders secured their supply, as motorists store up on gasoline? I also had a chance to experiment with Galvanization: either Interrupted or Continuous. There are times when one would like the privilege of interrupting certain continuous treatments.

Released from these experiences, one always had his fellow-sojourners to fall back upon and to converse with. What fun it is to talk of one's internal machinery and compare notes thereon. It is an endless source of conversation. It reminded me of a tourist trip out Colorado way and of registering at a hotel which proved to be a "one-lunger" hostelry. For years, thereafter, I felt sure the white plague had seized upon me as a victim, as imagination rioted on the suspicion and my home doctor refused to diagnose anything of the kind. Yet I shiver still over the memory of the unfortunates whose sole theme of talk was their poor surviving lung.

So here, one becomes infatuated with the game of swapping experiences as to one's aches, pains, feelings and suspicions. There was an infinite variety of complications; real and imaginary; physical and mental; but when a poor emaciated brother, trying to smile cheerfully, asked—

"When do you have your operation?" this particular guest-patient fled. The game was up; the week-of-his-life was clearly ended, and, with a final glimpse of the tower of the Institution and of the cemeteries twain, he used up his return ticket on the homeward journey, saying to himself,—*"Blessed be health."*—*Saturday Night.*

COMMERCIAL DEPARTMENT

Dix-Make Uniforms

WHEN a firm sets out with a determination to produce the very best article of its kind, and surrounds itself with a capable, carefully trained organization, the result is an article of such superior merit as to win a wide recognition.

To such types of concerns belongs the Henry A. Dix & Sons Company of New York. Its product—Dix-Make uniforms for nurses—has a remarkably large demand and a loyal following among the better dressed nurses both in the States and in Canada. It was this brand which was selected by the U.S. Government as the officially recognized make during the war. Dix-Make uniforms are still the officially prescribed garments in the U.S. Government Schools of Nursing. Strictly reliable in every sense, made with great care and precision and cut along smart, easy-fitting lines, they are considered the very nicest uniforms it is possible to buy in ready for wear garments. The company is pleased at all times to mail an attractive illustrated booklet and list of appointed Dix dealers.

The "White Line"

SEVERAL new items of hospital equipment have recently been placed upon the market by the Scanlan-Morris Company, Madison, Wis., manufacturers of the "White Line." Chief among these items is a combination blanket warmer and salt solution cabinet, electrically heated. The cabinet consists of two sections; the upper section designed for the storing and heating of salt solutions in flasks, and for keeping the solution at the temperature desired for immediate or for emergency use; the lower section, fitted with brackets over which blankets can be folded. The "Speedway" is a new "White Line" instrument and dressing cabinet designed for the Speedway Hospital of Chicago, for use in secondary operating rooms, examining and dressing rooms. The upper section of the cabinet contains four broad shelves for instruments; the centre section is composed of two drawers for sundries; and the lower section con-

sists of a roomy compartment for dressings, towels, etc. The cabinet is set on short legs, making a total height of 67 inches, and each section readily accessible. Another new piece of equipment which is creating considerable favorable comment among hospital workers is the "White Line" Maternity Bed. With this bed, which is also an operating table, all positions necessary for delivery and for operative work—full length horizontal, short delivery position, operative genecic position, Trendelenberg—are quickly and easily secured. In building "White Line" hospital furniture and sterilizing apparatus, it is the aim of the manufacturers to build into this equipment all the quality possible. High-grade materials and careful workmanship are combined in the "White Line" to make a distinctive product, and one destined to give satisfactory service under strenuous hospital conditions. Among Canadian hospitals now using "White Line" equipment are: The Toronto General Hospital, Toronto; Royal Victoria Hospital, Montreal; St. Martha's Hospital, Antigonish, N.S.; Ottawa General Hospital, Ottawa; Queen Alexandra Sanitarium, London, Ont.

Seal Brand Coffee

THERE is nothing so refreshing to the convalescing patient as a "real good cup of coffee." In order, therefore, to satisfy such a patient, Hospital Purchasing Agents should specify none but "Chase & Sanborn." It is the pure article and has an aroma and flavor all its own.

Gelineau's Dragees in Epilepsy

THE following clinical cases speak for themselves:—

N. M. Male, aged 18; asylum patient, convulsive seizures since 7 years of age. Post-epileptic maniacal attacks. Six months' treatment with Gelineau's Dragees in progressive doses. Complete disappearance of exaltation phenomena. Great diminution of the convulsive attacks, which are reduced to a very mild form. Freedom from mental aberration, able to return to ordinary life.

M. J. Lady, 28 years of age. Well educated, cultivated person of artistic tastes.

No hereditary tendency; *subconscious convulsive attacks*, before and after the menstrual periods. *Hystero-epilepsy*. Treatment by Gelineau's Dragees during twelve months. Entire disappearance of the convulsions.

Z. P. Male, aged 43. Asylum patient, certified for psychosis epileptica.

Daily convulsive seizures frequently following closely one upon another until producing a comatose condition. Large doses of bromide during many years without benefit. Great mental debility. Treatment by progressive doses of Gelineau's Dragees; considerable diminution of the convulsive seizures.

No aggravation of the dementia.

Gelineau's Dragees are obtainable in Canada from Messrs. Rougier Freres, 63 Notre Dame Street E., Montreal.

Chewing Tobacco Aids Thinking

It may be reckoned as a favorable sign that the new President of the United States is a devotee of tobacco in many forms, for besides being a smoker, President Harding finds enjoyment in chewing tobacco. Although Ex-President Wilson is not a user himself, he agrees with Harding to the extent of recognizing the advantage of chewing tobacco in helping men to think. It was Woodrow Wilson who said: "A Western Senator often is more useful than his Eastern colleague, because sometimes he chews Virginia leaf."

Pure Confectionery

As physicians know, patients convalescing from what may be a prolonged illness, particularly in fever cases where the temperature has been high and thirst a more or less prominent symptom, appreciate very much a moderate amount of candy, not only to take away the taste of their medicine, but as a means of removing the fur from the tongue. It is of the highest importance that such persons be given only the purest and the best of confectionery. If their friends in purchasing will just bear in mind the name "Neilson's," they can rest assured that they are getting the finest obtainable, such candies having a definite "food value" and most refreshing to young and old whether in sickness or in health.

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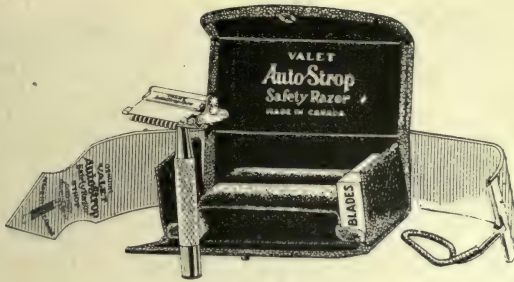
The Color of Cocoa

ONE of the interesting things about cocoa is its color, and it is one test for purity that the housekeeper can easily apply by purchasing a can of Baker's Breakfast Cocoa and noting carefully its rich, red brown color. This is the natural color of high grade cocoa beans unchanged by the action of chemicals. When cocoa has been subjected to the chemical or so-called "Dutch" process it takes on a much darker color, sometimes nearly black.

In the manufacture of Baker's Cocoa no chemicals are used; after being carefully selected and roasted the cocoa beans are ground exceedingly fine and a portion of the oil or cocoa butter is taken out by hydraulic pressure.

A Scientific Accomplishment

Remarkable advances have been made in the study of blood-clotting and hemorrhage during recent years. Not only have we learned much of a practical nature concerning the "mechanism" of blood coagulation, but we have also discovered means to control even inaccessible bleeding when, as is often the case, it fails to cease spontaneously, due to defective coagulability of the blood. The blood is kept in a fluid state in the vessels by the presence therein of antithrombin. Should the proportion of antithrombin be unduly increased and a hemorrhage occur, the blood would fail to clot. The absence or insufficiency of prothrombin or kinase, which perform an important part in the process of coagulation, would have a similar effect. Hence in the treatment of uncontrollable hemorrhage the physician needs an agent that can be depended upon to meet both of these conditions. Such a substance is Hemostatic Serum, P. D. & Co., a comparatively recent addition to the list of highly scientific remedies that have been elaborated by experts in physiologic chemistry. Hemostatic Serum neutralizes antithrombin and supplies prothrombin and kinase. Its effect is truly remarkable in the treatment of capillary hemorrhage, hemorrhage of the new-born, pulmonary hemorrhage, persistent epistaxis, bleeding from gastric and intestinal ulcers, hemorrhage following surgical operations upon the tonsils, the bones or the viscera, and so on. It is administered hypodermically or intravenously in doses of 2 to 5 cc, and the dose may be repeated at intervals of two to six hours.



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"The Bloodless Phlebotomist"

IN the Comedy Relief section of the May issue of "The Bloodless Phlebotomist," a delightful satire entitled "Too Late Now," by James Montague, gives a mirthful view of gland transplantation vs. euthanasia at sixty. This is only one of several worth-while features of this publication. J. Petrie Hoyle, M.D., the first American physician to serve in Flanders during the World War, contributes a very interesting article on war injuries, and the article on "Treatment of Inflammation of the Fallopian Tubes," by Dr. J. Sidney Eason, Coldwater, is well worth reading.

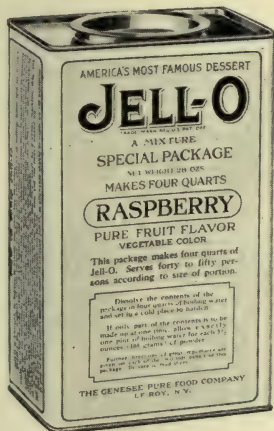
If you have not received this little journal a request to The Denver Chemical Mfg. Co., New York City, will bring, without expense to you, the May number, as well as future issues.

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BORN in the States and in Canada the Institutional size package of Jell-O, making one gallon of jelly, is meeting with ready acceptance for its convenience and for the high standard of quality that has always characterized the Domestic size package. There seems to be almost no diet requirement where the gelatine jelly may not be used. It may be a part of a liquid diet, a semi-solid diet or a convalescent diet. It is cool without being frozen, solid without being hard. It appeals to the eye as well as to the taste, and it furnishes easily assimilated nutriment in the way of sugar and protein, these two elements forming 80 per cent. and 16 per cent. of the powder respectively.

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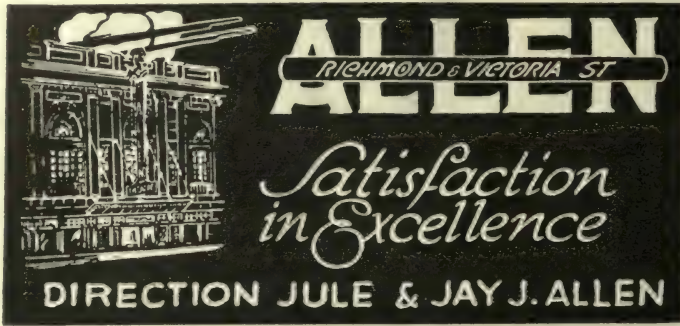
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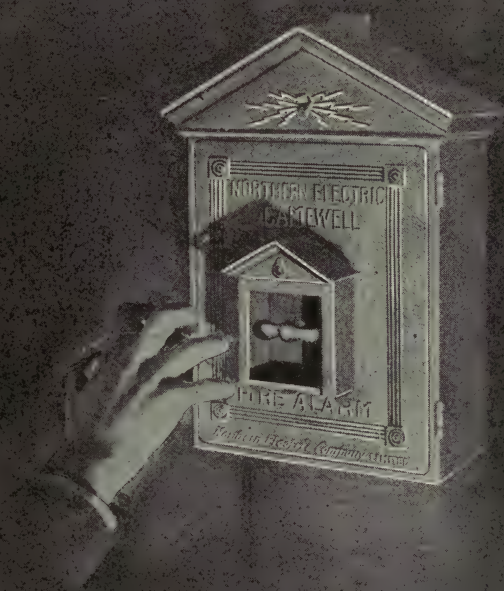
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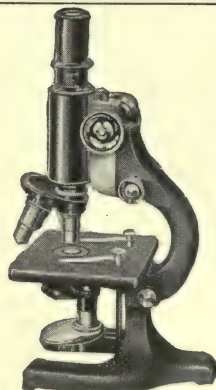
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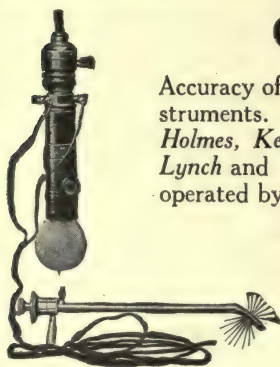
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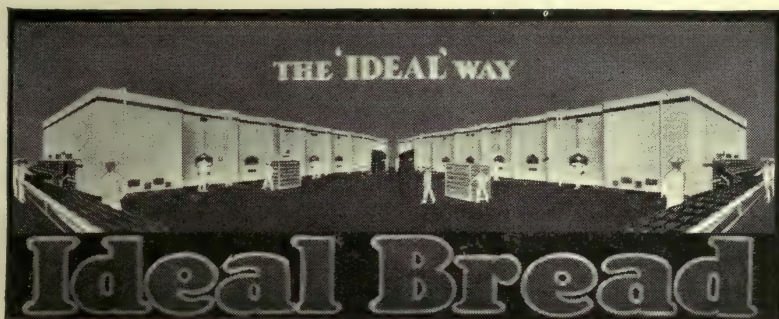
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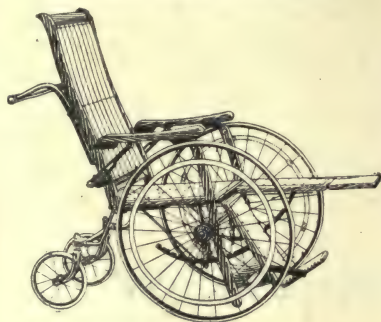
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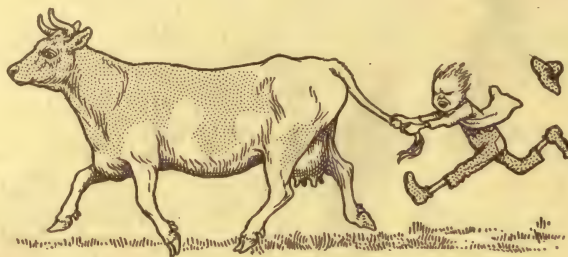


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Toronto, Aug. 1921

No. 2

CONTENTS

EDITORIALS

Getting Together	Page 31
The Environs	32
Cleanliness	33

ORIGINAL CONTRIBUTION

The effect of Sunlight upon White Men, with special reference to the Canadian West, by Chas. H. Huestis, M.A., D.D., Red Deer	36
The Public Health Nurse, by M. Powers, M.D.	52

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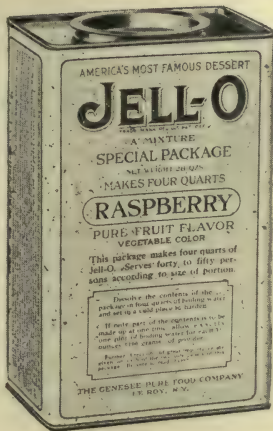
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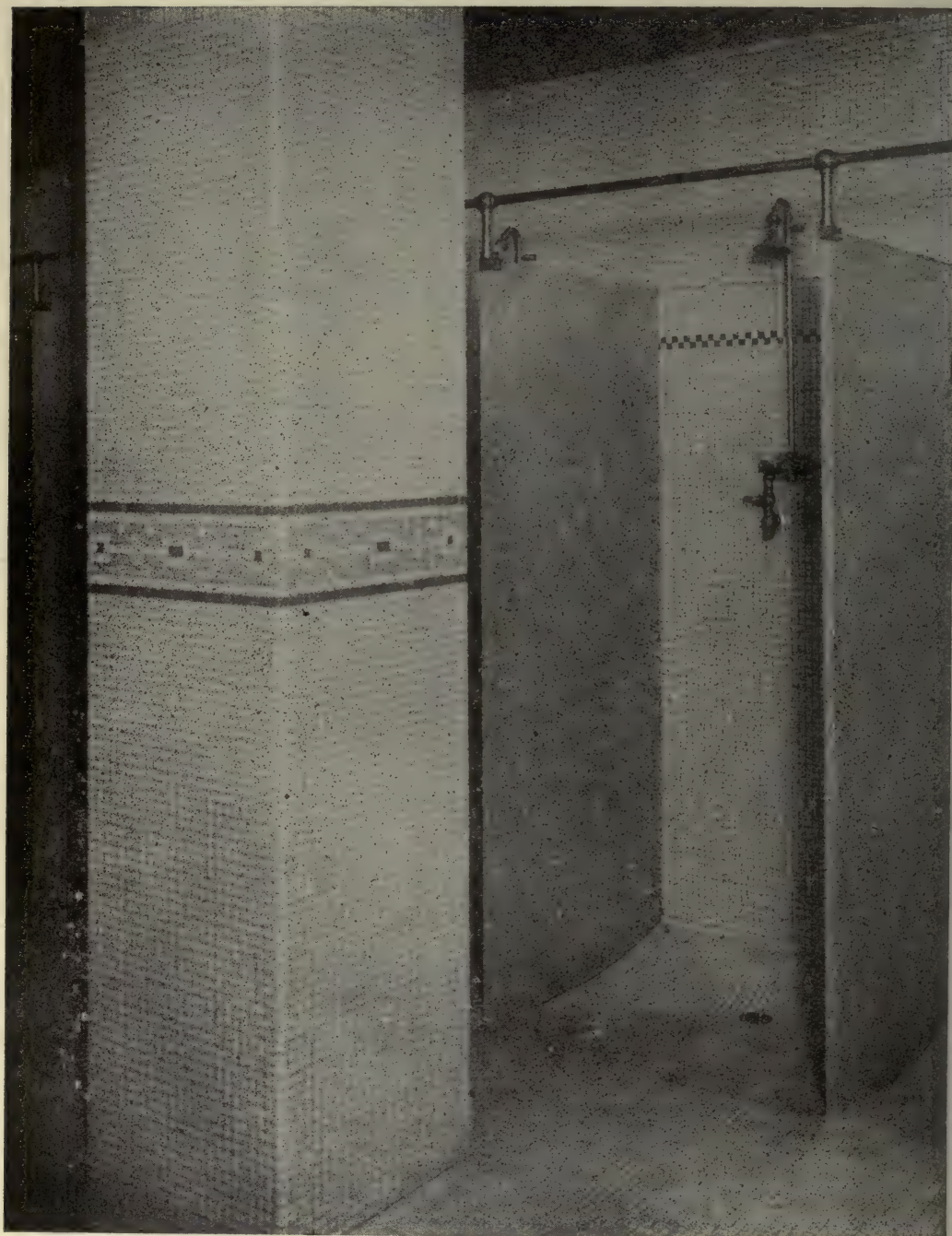
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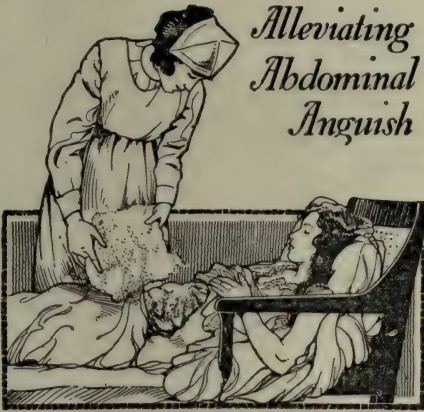
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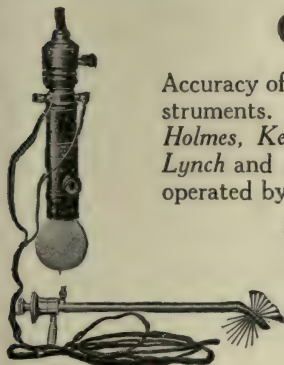
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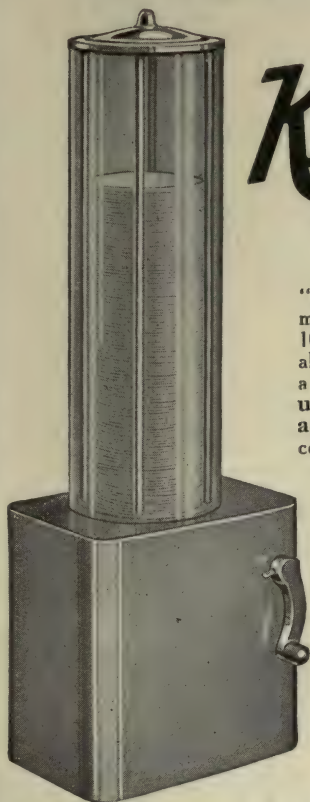
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The Hospital World

TORONTO, CANADA

**A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire**

Vol. XX.

TORONTO, AUGUST, 1921

No. 2

Editorials

GETTING TOGETHER

THE medical staff of standardized hospitals are supposed to hold monthly meetings, at which a review is made of the work done, consideration given to pending problems, and an outline made of projects to be undertaken.

Such meetings will make for harmony among the members of the staff, and will tend to reduce the friction to the minimum.

Even in hospitals which do not come up to the standard there is no reason why this good rule should not be observed. In the hospitals in the smaller towns all the practising physicians in the place are as a rule in the medical staff. In quite a number of these towns there is often a spirit of jealousy or bitterness which does injury to the profession as a whole. Such things ought not to be. One way of

preventing the occurrences of these unpleasant conditions is to have frequent meetings and free discussions on points of difference as well as in points of agreement.

Men cannot do first-class work nor live happily if discord prevails among them. In every way it pays to "Let Brotherly Love Continue."

As with the medical staff, so with the administrative departments of a hospital—particularly of the larger institutions. The superintendent is wise who meets weekly in council with the superintendent of nurses, the chief medical house officer, the matron, the engineer, the steward and any other departmental heads to discuss any and all subjects in which they may be commonly interested. He will glean much information of a helpful nature from such conferences, and every departmental head will be stimulated by such intercourse and great good will accrue to all, which will reflect itself in the character of the work rendered by the hospital as a whole.

THE ENVIRONS

WHILE the main energies of hospital folk are centred on the inside of the hospital—the wards, operating rooms and equipment generally—looking toward the comfort of the patient consigned to his bed, the outside must not be forgotten.

How important the first impression of an incoming patient! The setting of the building and its out-

side appearance—they do much to make or mar the reputation of a hospital.

We have always stood for the suburban location. The sick man, like the well man, enjoys the open spaces, where he can get a view of cloud flocks and blue sky fields; of rolling country with smiling fields of grain and meadow; of grazing herds and singing birds; of groves or copses or wood lots in the distance with plenty of friendly trees in the foreground; with flower gardens and grassy terraces; with ponds or running streams. All these make for quick recoveries and short convalescences. Nowadays verandah, and, even when lying, can enjoy the direct sunshine, the fresh air free from dust and smoke and the quietude which does so much to compose their nerves and minds. How much better are they thus remote from the fume and din of the city!

So hospital trustees should see to it that the building they erect has all of the advantages they enjoy in the mansions and palaces in which many of them dwell. If the country is the ideal place for the well, how infinitely more important for the sick!

CLEANLINESS

THE up-to-date hospital may be kept clean with the minimum amount of effort and expense. Unfortunately there are only a very few up-to-date hospitals in so far as relates to lodging places for dust. Even some of the most recently built are not as perfect as

they might be. In only a few do we find coved bases and rounded ceiling angles; no ledges anywhere; baseboards flush with walls; large window panes instead of small, glass door knobs, tops of cupboards—such as are not in the walls slanted downward and forward; floor drains in operating rooms, kitchens, sickrooms; absolutely plain doors, push plates on doors, and the many other devices for prevention of the accumulation of dirt and for easy cleaning generally. Numerous base plugs for vacuum cleaner attachments should be provided. Walls should be of durable color, with smooth and washable surface. The lower four feet darker in color to withstand the discoloration of soiled hands. The wall base should be eight or ten inches in height, thus protecting the walls from splashing from floor scrubbing.

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The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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Original Contribution

THE EFFECT OF SUNLIGHT UPON WHITE MEN WITH SPECIAL REFERENCE TO THE CANADIAN WEST

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I MUST apologize to you, gentlemen, for inflicting my views upon you. Being a layman I am not able to discuss the matter in hand with the technical efficiency to which you are accustomed and doubtless you will be ready with criticism when I am through. I do not hope to convince you all of the truth of my thesis—especially those of you who happen to be over forty years of age. I am myself, however, convinced of the general truth of my theory, and I believe the future experience in this country will bear me out. The matter is one of first importance, as it seems to me, to our western civilization.

Perhaps, I may begin by stating the movement of my own mind in the development of the thesis of this paper. I had spent a number of years in the semi-tropical islands of Bermuda, and I was again and again impressed with the similarity of much of the West with what I had experienced down there. And yet the climates of the two places were so dissimilar. One day, while reading an article upon the effect of sunlight upon protoplasmic matter, it flashed across my mind that in this direction lay the solution of the problem. Though the West differed from the tropics in climate, yet they were alike in one particular, namely, that both were regions of almost constant sunshine. "Sunny Alberta." How we have loved the name, and gloried in our sunny skies. And well we might, for are they not the creators of our wealth? But what if this sunshine, which is the promise of our harvests, is at the same time the source of

many of our bodily ills? If white men were not able to live permanently in the sunny lands of the South, might they not be forced to abandon the equally sunny lands of the North? Acclimatization had not been possible there, would it prove possible here?

In discussing this question I found the literature very scanty. Von Schmaedel had made an interesting study of the pigmentation of the skin of races living in sunny countries. We have also an ever-increasing literature upon the effects of light upon the human organism, and especially of late as to the therapeutic effect of radio-active substances. This, it has been learned, is due to the chemical effect of the ultra-violet rays upon the cells in the way of stimulus. Finsen proved that the alterations to the skin which occur when exposed to intense light were due to these rays, and by their application he was able to destroy certain *foci* of disease. This stimulated further study of the therapeutic action of light—particularly the fruitful researches of Bernhard and Rollier as to the effect of light upon internal maladies. The study has been still further carried on by Van Tappleiner who discovered that the effect of light rays upon living organisms was modified by the presence of dye stuffs—infusoria perishing when the dyes were dilute, but remaining alive in denser solutions. Dr. Fritz Schans in a recent article published in the *Scientific Monthly* (January, 1920) has demonstrated that the form of plants is altered by light waves of short length and chiefly by ultra-violet rays. He thinks the colors of plants have for their function the selection of rays beneficial to growth, and not to charm insects and bees to assist them in the process of fertilization, as is the popular idea. They act, he says, as sensitizers in the same way as the chlorophyl of green leaves, and they also act as a protection against rays that would be harmful. Two Frenchmen, Bohn and Marre, have written upon the effect of sunlight upon white men, and their theories have made a profound impression in Europe. But, perhaps, the most important contribution to the subject is a book I found in the course of my investigation, entitled, "The Effects of Tropical Light Upon White Men," by Major C. E. Woodruff, U.S.A. I am particularly indebted to this investi-

gation of the subject in the preparation of this paper, though I had reached my conclusions before I read this book.

I will discuss the following points:

The effect of light waves upon living organisms.

The pigmentation of the skin of races whose habitat is under sunny skies as a defence against the effect of sunlight.

The pathology of sunny lands inhabited by white men.

Some practical suggestions as to the habits of white men who desire to live in the West of Canada.

1. A brief resume of our present knowledge of light rays may be helpful. You are familiar with the new conception of matter which has arisen as the outcome of the study of certain radio-active substances. Instead of the old conception of matter as composed of invisible, metaphysical, units called atoms, the idea now holds that atoms themselves are divisible, and are composed of smaller particles called corpuscles or electrons, which dash to and fro within the atom and revolve with inconceivable rapidity. You know how under the conditions of a Crook's tube an electric spark will produce dis-association of these corpuscles, which rush forth in a stream and produce ether stresses which are known as *cathode rays*. Certain substances such as radium seem to possess the power of giving forth a constant stream of corpuscles, producing stresses which are known as *Becquerel rays*. We use the word "stress" because it seems to be what is produced when a stream of corpuscles is started or arrested—a stress is given to the ether which is carried outward at the velocity of light. These stresses follow one another at intervals, and the length of these intervals—or waves, to use the old term—constitute or determine the character of the wave. It must not be forgotten, however, that these waves are not to be conceived as movements of the ether, which is an immovable substance, but simply a stress of the same, as when a hammer falls upon an anvil imbedded in concrete the stress is carried from top to base, though the anvil itself does not move.

Now the slowest and longest variety of waves that have been discovered are called *Hertzian*. These, as you know, are made use of in wireless telegraphy. Waves shorter still affect the body as heat; shorter still they have the power of affecting the

retina of the eye and producing what is known as the consciousness of colors—red, yellow violet. Beyond the violet there are waves still shorter which, though they do not affect the retina consciously, produce effects upon certain chemical substances and are used in photography. They are also of incalculable value in the elaboration of the energy of plant life.

Some years ago certain rays were found even shorter and quicker than the actinic rays of the sun—so short, indeed, they proved to be that they can penetrate certain substances without disturbing their corpuscular arrangement. These were called by their discoverer, Roentgen, "X-rays." Later M. Curie and his clever wife made discoveries in the powers of radium, and found that this substance emits particles which flow in fairly slow streams but which impart stresses of great velocity and rapidity.

There is no need that I do more than point out to you these facts which are so familiar; but let us not forget that in all these different varieties of light waves, we do not have anything *new*. All are really of the same kind, and are produced in the same way, namely, by changes in the motions of the corpuscles which compose all kinds of matter.

Coming now to consider the effects of light rays upon living organisms, you are familiar with the therapeutic value of certain kinds of rays. You know how effective they are in reducing growths of a malignant nature upon the surface of the body. They also seem to be able to penetrate some distance beneath the surface of the body, but there they rapidly lose their efficiency. You know that they have an exceedingly stimulating effect upon living organisms, and are the source of all life upon our planet. You also are familiar, with the fact that exposure to the direct rays of the sun, especially in hot climates, is prejudicial to health, and often fatally so. We know that white men have not been able to make the tropics their permanent abode. More than this, we are quite familiar with the effect of sunlight upon bacteria, which succumb more rapidly to this than to any known antiseptic, so that perhaps the most effective disinfecting agency is the exposure of a room or garments which have become in-

fect, to the rays of the sun for a time. No bacteria are able to stand for long this bombardment; they love darkness rather than light! This is due to the extreme irritability of the protoplasm of which bacteria are largely composed. Protoplasm is chiefly nitrogenous, and there is no substance so easily set off as nitrogen, which, as has become familiar to us in the recent war, is the basis of our most powerful explosives..

In the temperature of the human body protoplasm seems to function most readily—but when the temperature is raised a few degrees trouble ensues, and unless the rise of temperature is arrested and reduced the organism perishes. You are acquainted with the destructive effect of radium. M. Curie has asserted that a pound of radium in a room would probably kill every one present by the power of its bombardment. A small particle of radium carried in the vest pocket produced a sore in the side which for weeks resisted every effort to heal.

Now the short, or actinic, rays of the sun are very similar to those of radium, and are also destructive, as seen in sunburn, glacier burn, and sunstroke. In the last named it is probable that heat combines with light to produce brain paralysis, but this is not so with glacier burn.

From the study of the effects of sunlight upon living organisms we find them twofold: 1.) The first effect is metabolism—increasing the oxygen carrying capacity of the red blood corpuscles. (2.) But when the process is long continued we have actual destruction of the protoplasm and the derangement of the molecule. The latter is also the immediate effect where protoplasm is not protected by some aqueous medium.

The metabolic effect of sunlight is most favorably studied in plant life. We must remember, however, that plants are the true children of the sun, and we cannot determine everything regarding the effects of sunlight upon animal life by studying its effects upon plants, but we can learn something. In the marvellous chlorophyll of the plant we see manifested the power of storing up energy of the sun's rays, energy that later the animal makes use of. In all plant life we find adaptive arrangements which have for their end the protection of the plant from the destructive effects of the sunlight. Every gar-

dener knows how necessary it is for some plants to rest awhile in the darkness in order to a sturdy and vigorous life. The plant also seems to possess the power of "stepping down" rays that might prove hurtful into forms more congenial, in some such manner as the transformer steps down the dangerous electricity on the mains so as to protect our dwellings. It must also be remembered that while the protoplasm of plants and that of animals are the same, the function of the plant is really to store up energy so that it may be of use to animal life. The plant must have sunlight in large quantities, it is necessary to its growth. But to man and animal life it is not so necessary. Animal life thrives upon very little sunlight, or none at all. This is, of course, heresy in the face of the common notion as to the blessing of sunlight; but it is very doubtful whether sunlight is *directly* beneficial to animal or human growth and development; and too much of it is certainly harmful, especially when nature has not provided protection against it, as it is with the colored races and with some birds and animals which have sunny places for their habitat. Since this is heresy let us think about it for a little while.

It is interesting, in the first place, to remember that animal life is naturally aquatic. Human life begins in an aquatic medium, and at a certain period of prenatal life is equipped with gills. The rhythms of life seem to point back to a time when the effects of the tides were felt as vital stimuli. The majority of the cells which compose the body are aquatic in habit and marine at that, requiring a saline solution in order to vigorous existence. Now water absorbs the ultra-violet rays of sunlight, and thus protects the cells which could not otherwise exist. The liquid in which the brain literally swims, is not simply nutritive, it is also protective, like the hair upon the scalp, from the destructive actinic rays.

It is interesting to consider further, that most animals, like the cat, are nocturnal in habit, passing the day in dens and the hollow of logs and trees, in holes in the ground, and coming out at night. This is true also of the natives of sunny climes. The negro is by nature a nocturnal animal, preferring to spend the day in sleep and coming out at night to sing and dance by the

light of the moon. Animals that live in the daylight are protected by fur and feathers and the pigmentation of skin from the sunlight, the parts most exposed being darker than the rest; while naked animals like the rhinoceros and the elephant, have a dark skin. Black ants live in the sunshine and white ants come forth at night. Ants place their white eggs in the sunlight for a short time every day, but when the sun becomes oppressive they remove them to their nurseries.

All these instances, and they might be largely multiplied, prove that nature and instinct protect animal life from too great sunlight, indicating that while small quantities of sunlight are doubtless beneficial, though it is probably its warmth that is the attraction, in larger measure it becomes hurtful and even positively fatal.

2. When we pass from animal to human life we find a new factor presenting itself, namely, *reason*, which makes it difficult to prophesy much from the lower standpoint. Reason modifies instinct and often flatly contradicts it. Men have most of the instincts of the animal—and then some, but they will pursue lines of conduct contrary to both instinct and reason if these lie in the path of desire.

However, we find that when we study the life of mankind with reference to our theme, that both nature and reason combine, the one to protect, and the other to seclude him from the rays of the sun. As we study the distribution of the races of mankind upon the face of the earth, one fact stands out prominently, namely, that nature has provided that the skin of mankind is dark or light in proportion to the sunniness or cloudiness respectively of the land which is his true habitat. The degree of heat seems to be immaterial, for we find that both Arctic natives and those of the tropics are equally dark complexioned, the former for protection from the reflected sun glare, the latter from its direct rays. Only in cloudy lands do we find white men at home. This fact may be formulated into a law of whiteness, namely, "*The whiteness of a people is in proportion to the cloudiness of the skies under which they live.*" Cloudy and foggy lands are, and have ever been inhabited by big blonds; sunny lands by little, dark men. Compare the big

yellow Swede with the little dark Italian. Think of the immense amount of virile force and intelligence which has come from the fogs of Ireland and the north of Scotland to aid Britain in her conquests of war and peace. The reason why men in sunny lands are dark is, of course, because the dark complexion cuts off the actinic rays of the sunlight which are so dangerous to animal protoplasm.

It would seem that we shall have to revise our old ideas as to the unvarying benefits of sunlight, at least for white folks. In the earliest days our ancestors followed instinct more than we do now—and were more robust—they avoided the sunlight and spent as much time as possible in the shade. And this is the case to-day with people of little culture; in spite of the doctors they persist in darkening their homes. A great deal of the eye trouble which is becoming prevalent among children is due to too great exposure to sunlight. The instinct of the mother is to put her baby for his morning nap in a quiet darkened room, until some doctor gives orders that the veranda or the door step is the place. Then you have a child stimulated to an activity and development far too rapid, and later on anemia and arrested development.

The custom too of placing hospitals so that every room possible is flooded with light is not good therapeutics, as it seems to the writer, and many a patient would make more rapid convalescence if shielded from the irritating rays of the sun. Were it not for autohypnotic suggestion the recovery would be more retarded still. The patient has been made to believe that "sun baths" are the great thing, and "belief" helps, as the Christian Scientists have proved. But the truth would seem to be that while sunlight should be permitted to bathe every sick room for some time during the day, provision should be made by means of Venetian or other blinds or shutters, for shutting it off most of the time. Fresh air is imperative and should be provided by forced ventilation.

I do not think it will be necessary for me to spend more time in seeking to demonstrate the truth of the law of whiteness given above. There is another fact equally demonstrable, and that is that white men have never been able to permanently

live in sunny countries. This is a large question involving the migrations of the race through all its history; we have not time to go into the question. But think of India. This is a sunny land which has been ruled by white men for some generations. But no white man dares live there for any great length of time, nor does he attempt to bring up his children there. If he does so they quickly wilt. There is no third generation of whites in India, I am told on good authority.

Of more interest to us is the presence of white men upon the American continent, especially those parts of the continent most exposed to sunshine. The natives of this continent were dark and red men. The people who now occupy it have come mostly from Europe, the more aggressive and progressive from northern Europe which is cloudy and the habitat of blonds. Under the sunnier skies of America there has been developed an aggressive force unparalleled in the history of the world—so much for the stimulus of sunlight. There has also at the same time been produced a new disease—or rather a new phase of an old one—namely, *Americanitis*—so much for the too great stimulation of sunshine. It is not hard work that breaks down people who live in Western America and Canada. Hard work is wholesome—most people do not do enough of it. It is nerve exhaustion due to over stimulation from sunlight. Of course, there are other causes—the artificial life of modern times, etc., but I am persuaded that the chief cause is as indicated.

The mortality of blond people has been much greater in the United States than of dark, so that the continent is being peopled by dark men; these survive, the others go down, or become unproductive, and have no or few descendants.

The first feeling on coming to Sunny Alberta from the far east is one of increased well being and of greater inclination to activity. New comers exult in the climatic conditions and write home enthusiastic letters about it. But after a few years they begin to feel the effects of this constant stimulation. The women break down more quickly than the men, as we should expect. It is known that suicides and insanity are more common during bright months of the year than during the dark. School teachers in the west tell me that they dread the sunny days.

for while the children are brighter and quicker, they are much more hard to manage than on cloudy days—as we should expect again.

The remarkable success of sanatoria on the Atlantic coast may be partly explained by the comparative absence of bright sunlight due to cloudy skies, and the consequent restfulness; and, perhaps, the most important part of the Weir Mitchell rest cure is the removal of the patient to a darkened room. Careful studies made in the sunny States of Western United States reveal a great prevalence of neurasthenic and apeptic conditions, and this is true of my own and other's observations in Alberta. These are usually greatly helped by a sojourn at the Pacific Coast, where the clouds, like a "divine umbrella," give the sufferer relief. This may also explain the instability of the peoples of the West, where all sorts of vagaries, political and religious, seem to have their origin. The Britisher, who seems to have no nerves to speak of, takes his morning plunge in ice-cold water and goes forth to conquer the work with a codfish expression on his face, and confirmed indisposition to hurry; but he will stand more than your nervous, high-strung American, who produces results while the Britisher is thinking over what to do next.

Some years ago Dr. Clouston, one of Scotland's greatest alienists, visited America, and while there said some things worth remembering.

"You Americans," he said, "wear too much expression on your faces. You are living like an army with all its reserves engaged in action. The duller countenances of the British population betoken a better scheme of life. They suggest stores of reserved nervous force to fall back upon, if any occasions should arise that requires it. This inexcitability, this presence at all times of power not used, I regard (said Dr. Clouston) as the great safeguard of our British people. The other thing in you gives me a sense of insecurity, and you ought somehow to tone wourselves down. You really do carry too much expression, you take too intensely the trivial moments of life."

To the same end was Herbert Spencer's address at a dinner given in his honor as he was leaving the United States some years ago. He took for his theme "The Gospel of Relaxation"

and preached a sermon like that of Clouston above. But neither the alienist nor the scientist saw or mentioned the chief cause of this intensity—this “bottled lightning,” as some one has called it, kind of personality which characterizes the American people, and the Canadian people too. It is climatic, and is due chiefly to the fact that a race of men is attempting to live and develop under skies to which they are not fitted, owing to their white skins. Professor James says that Americans must cultivate the habit of relaxation or perish, and he is right in the opinion of the present scribe. Instead of strength we are cultivating what Clouston calls a sort of “irritable weakness,” which produces results rapidly, but at an awful cost. The problem is an important one and demands earnest study.

It has been stated that the death rate in the U. S. increases with the amount of sunshine, but I am not able to corroborate this statement. But I am informed that consumptives in the later stages of the disease, who come to the west go off with great rapidity, and physicians of California have warned eastern doctors not to send such patients out there. There is also a growing conviction that some nervous weakness is one of the predisposing causes of tuberculosis, and this sunshine can only intensify. Of course, here again the complexion of the patient has its part in the problem, and it is as important, as some one has put it, “to know what sort of a patient the disease has got as to know what sort of disease the patient has got.”

But I need not pursue the matter farther. I have placed the subject before you to the best of my ability, for your consideration. I believe it to be worthy of the same, and I hope some one more competent than I will carry the investigation to completion. I shall close with some practical observations.

4. Let us keep carefully in mind the two-fold effect of sunlight upon the human organism: First, increased metabolism and consequent larger excretion of carbonic acid; next, nervous exhaustion. Remember also that blonde men and women suffer more than dark from the stimulation of sunlight. What then are the practical conclusions as regards conditions of life in Western Canada?

Here we live under the sunniest skies in the world, outside extremely arid regions which are unpopulated, or scantily so. It is true that the effect of the sun's rays is moderated by the latitude and also by the altitude of our west land, but this is true only of the longer rays of the sunshine. Of the shorter, actinic, rays we get the full benefit, and these are the ones so destructive of protoplasm. Besides our altitude produces more rapid heart action, which helps on metabolism. Can it be that what has proved true of the inability of white men to colonize permanently other sunny climes in the past will find an exception here? I cannot see how this can be loath as I am to come to this unsatisfactory conclusion. Indeed, you doctors are finding the truth of my conclusions in your practice every day. You are meeting, so some of your number inform me, with neurasthenic and other conditions almost entirely due to loss of nervous vigor. Uric acid conditions seem to be especially prevalent, and exceedingly stubborn to treatment. The etiology is simply inability on the part of the nervous system to control the chemistry of the body. And this is complicated by the instinct to seek large nutrition with the consequent overloading of the digestive organs. Anything which tends to lower the nervous tone is a menace to the entire system, and will manifest itself in the weakest part of the organism. So that many complaints whose origin is obscure are probably due to lack of nervous vigor, due to excessive stimulation from sunlight.

Personally I have come to the conclusion that white men will not be able to permanently colonize the West of Canada outside British Columbia, west of the mountains. In two or three generations they will have learned their lesson. The only extenuating fact is the marvellous productivity of this country which will make it possible to get out after having made "our pile."

Meantime the practical question is, what can be done to mitigate the evil effects of sunlight so that life may be made endurable, and residence in the West prolonged. This question is of even greater importance when we consider the interest of the rising generation, whose energies are so occupied with the processes of growth and development that they are less able than

adults to withstand extra pressure. We must certainly change our habits of life from those we have been accustomed to and live more like they do in the south. We must not only protect ourselves as much as possible from the sunshine, but we must also cultivate habits of rest and relaxation. Early to bed and early to rise must be the rule with a siesta at midday. You haven't time to do that? Very well, nature will see that you take time a little later on.

Instinct has already done something to suggest accommodation to conditions of life here. The typical house of the west—the bungalow cottage, all on one flat with a wide, shady veranda—is the right sort of house to live in. Windows should be protected by green blinds or shutters which can be closed during the sunniest parts of the day, and which admit of ventilation. In the south every one retires within darkness in the middle hours of the day, and this may be necessary here, and certainly should be the rule for women and young children during the summer months.

The formation of improvement societies in all our towns and villages would be a good movement, with a chief function of encouraging and assisting the planting of shade trees about the homes of the people. Trees absorb large quantities of sunlight and thus protect the dwellers beneath them. Our remote ancestors had a penchant for trees, and spent much time in swinging from branch to branch in unbrageous shades. It must have been good for them.

In the interests of childhood certain changes in the length of the school day and the school year are certainly indicated. The school day ought not to be longer than from 9.30 in the morning to 3 in the afternoon for older children, and from 9.30 to one for the younger, with recess at noon for the former and at 11 for the latter. The school year should close not later than the first of June; or even earlier would be better, and all examinations for grade—if examinations must be held—should be in April. It is a curious state of affairs that while we hold the examinations of University students in April, when the forces of life are strong, we hold those for boys and girls when these are largely exhausted. Teachers complain of this and say

that larger numbers would pass were the examinations held earlier in the year. The month of June spent in school is a positive waste of time, which would not be so serious were it not a cause of nervous irritation and arrested development. Just as it is true that men live not by what they eat, but by what they digest, so it is true that they are educated not by what they study, but by what they assimilate. Fatigue is the deadliest enemy of the development of children—Gots Muts calls it a positive disease—and they should be carefully guarded from the same. Attention, too, which is the supreme achievement of civilized man, is impossible when the nervous forces are at a minimum.

The windows of the school room should be so arranged that the lower parts can be darkened and the light come in from above. Walls should never be white, which reflects all the rays of the sun, but green, yellow, or terra cotta. Yellow, which is so pleasing to young children, is probably the best color.

In speaking of these matters may I call attention to the recent effort made on this continent to lengthen the day by the simple, but foolish, device of putting the clock back an hour. It was tried one year in Alberta, and that was enough! It will never be tried there again. Living in a country where during the summer it is possible to read your newspaper out doors at ten at night, it would hardly seem to be necessary to increase the length of the day still more by adding an hour to the morning. It proved to be a positive crime against childhood, adding practically two hours to their already too stimulating day of almost constant sunshine. If the dwellers in eastern cities desire this sort of thing, they are welcome to it, but they must not seek to make it a National law.

Continuing our theme of the habits for the West, I would say that it might be the part of wisdom to imitate the people of the sunny south by dressing in colors which intercept the rays of the sunlight which are hurtful. Where outer garments of light color are used the undergarments might be black or yellow. Animals which have white fur or feathers have a black skin. There is no being quite so happy and contented as a negro dressed in white. The habit of some women going about

in the day time with neck and shoulders bare, or covered with some flimsy material, is dangerous, as is the increasing habit at summer resorts of going bareheaded. The umbrella and parasol habit, so common in the south, might be cultivated by us with profit in the summer. These should be made of black, green or yellow material, never of white.

In social life women should confine their afternoon calls during the summer—if they make them—to the later hours of the afternoon—say between four and seven. The color of houses both inside and out, ought to receive attention in accordance with the color scheme mentioned above. White should be avoided as much as possible. During the day sunlight should be let into the bedrooms in plentiful supply, while they are not inhabited, but the blinds should be carefully drawn on retiring to protect the sleepers from the early morning sunshine which prevails during the summer.

The warm bath should take the place of the cold plunge so much affected by Britishers, as the latter are too stimulating. The nerves receive stimulating enough without this heroic treatment. It may be that I am opposing some pet theory, but I think the facts will bear me out. The warm bath taken in the middle of the day before the siesta, or at night before retiring, will be found most restful to third nerves and will relieve many insomnias. It may be that light draughts of alcoholic drinks will be indicated in cases where the digestive functions are arrested. It is now understood that alcohol is not a stimulant, but a sedative, and is helpful at the close of a day of nervous activity. Even in "bone dry" lands it can still be obtained by the potent aid of a doctor's prescription! In the south, curry is used in large quantities to promote digestion. This is an abnormal condition, but it is to be remembered that the thesis of this paper is that the life of white men in the West is necessarily abnormal.

In cases of neurasthenia and other like conditions due to loss of nervous control, it is doubtful whether a cure can be effected here. The course in cases which I have observed of such ailments is usually as follows: First a very marked improvement, due to increased metabolism, then a return to the trouble in an

exceedingly stubborn form. In all such cases a prolonged stay under cloudier skies is the thing. Fortunately we in Alberta do not have to go far for this, for the Pacific coast is near at hand, though in the summer time this region is also a sunny one.

As to the question of nutrition I have not sufficiently studied it to speak with even a degree of authority. But good nutrition is important to make up for exhaustion, and especially the nitrogenous foods and the free vegetables which are rich in vitamins. Rice as a vegetable might be made use of in the summer months as it is in the south.

Lastly, it is doubtful if persons of extremely light complexion should attempt to live in the West. To be a true inhabitant of Alberta the fashionable complexion should be that of a Cree or Stoney Indian. The following words of a woman who lived for some time in Colorado may be of interest to Alberta women:

"I wouldn't live in Colorado," she said, "if they gave me the State. There ought to be a sign on the boundary, 'Abandon all hope of complexion all ye who enter here!' Complexion! Why, there isn't one in the State. You cannot put on skin food fast enough to keep from being dried to the bone. The dazzle of light makes you squint till your face looks like a railway map for wrinkles. The climate braces you up till in your laziest moments you work like a steam engine. It stimulates you till your nerves are stretched to the highest tension, you walk on air, you talk fast, you fairly bubble with energy, and you think Colorado the most magnificent country on earth, till some day a friend comes out from a little dull town in New England, and after she looks at you she says, 'My dear, how you are aging!' People don't rust out in Colorado, they wear out. They do things in a year in Colorado which would take ten to do down east—and they show it in their faces. No Colorado for me, thank you. I don't want to grow up and old with the country. I want to stay where things stand still, and keep my complexion and my hair and my nerves." There is many a woman in Alberta who will say 'Amen' to all that. It is true that sunshine has a darkening effect upon the skin, but no white race has yet been able to get dark enough to stand permanently

tropical sunshine. It has been like the experiment of the French-Canadian, who tried to keep his horse without hay or oats; he had just succeeded, he claimed, when "Sie horse, she die."

People of light complexion go under quicker than dark, women quicker than men. The children suffer most, both directly and indirectly, for children begotten by parents whose nervous force is impaired cannot be vigorous. Nature balances the account by producing sterility in the third or fourth generation. In the meantime abortions are far too numerous.

I shall be glad to have your criticism of this paper which I am quite conscious is not as exhaustive as it should be. I hold no brief for the thesis outlined, and should be glad for my own sake and that of my family if it could be shown to be unsound. History is my great standby, and the history of past attempts to colonize sunny lands on the part of white men speaks with no uncertain voice. We shall do well to hear her words.

Meantime the medical profession can do much to make residence in the West more endurable. The public will take from you suggestions as to habits of life that they will not take from a layman like myself. If my theory is sound, then we should face the facts, and do what we can to meet the conditions involved. Having called your attention to the matter, my duty is done.

In closing to commend to you these words of John Morley:

"Things are what they are; they will be what they will be; then why should we deceive ourselves?"

THE PUBLIC HEALTH NURSE

M. POWERS, M.D.

THE task set before me to-day is to describe how the public health nurse could be employed in a rural municipality. The manner in which I intend to treat this subject is to ascertain, first and foremost, what the term "public health nurse" means, what is the nature of her activities, what work does she perform, what problems has she solved, in short has she given results in the localities where she has been employed that would justify

her continued and permanent employment. If this can be shown, I feel that, if, in our rural municipalities, we have similar problems to be dealt with, then we would be thoroughly justified in persistently and strongly advocating, on every possible occasion, the speedy introduction of this most valuable arm of the public health service into even our remotest rural districts, where it is probably needed the most. In this connection I will quote the eminent authority, Roseneau, who says that "the country is the weakest link in the sanitary chain," and that "each farmhouse represents in miniature all the problems with which the city deals by wholesale," and "is often not financially able to meet its sanitary requirements."

The varied literature on this subject gives us much valuable and interesting information, especially the many instructive pamphlets published by the Met. Life Insurance Co. and the United States Children's Bureau. From these we learn that at its inception in England almost sixty years ago public health or visiting nursing was intended solely for the indigent sick. No fees were charged and no recompense expected as those treated were too poor to pay. This method of nursing care was later taken up by other countries and its success was such among the poor that gradually it was extended to include the self-respecting and independent working classes, the largest element in our population who are unable to bear the expense of private nursing, especially if extended over any considerable length of time, and yet who are willing and wish to pay according to their means. This latter class now constitute the pay patients of most visiting nurse associations. The reluctance on the part of many who would rather do without nursing care than call upon or accept the services of the visiting nurse, whom they wrongfully look upon as only the charity nurse, has been one of the greatest drawbacks to the extension of this very valuable system,—according to the experience of Met. Life Insurance Co. This difficulty has been circumvented or obviated in New Zealand where the services of the Public Health Nurse—the Plunket Nurse—similar to the V.O.N., are now furnished free to rich and poor alike. This Plunket Nurse, called after Governor Plunket, who instituted it, covers the urban districts.

while the rural districts are attended to by the district visiting nurses paid directly by the government through the Federal Board of Health. Accordingly in New Zealand each and every individual has the benefit of the finest of nursing gratis, the taxpayers in general paying for it—an admirable system worth while studying, and which has given admirable results, especially in lowering the infantile mortality, though this has not been its chief and only aim.

The activities of the visiting nurse are manifold. She answers every call, concerns herself with the health of the community in general, as well as with that of the individual in particular and performs a double duty in that she cares for the sick and keeps the healthy well. She seems to have a special predilection in liking for the baby, for she starts to take care of him even before he is born in the pre-natal care she furnishes the expectant mother, remains with mother and baby in the lying-in period, and for the next few years, his most trying ones, keeps a watchful eye on him in the welfare stations, milk depots or baby clinics when she is not visiting him in his home. Later on, as the school nurse, she is his constant attendant, guarding him against the preventable diseases (especially tuberculosis) in her lessons on personal hygiene, and furthermore detecting in him physical defects, whose early removal means in later years all the difference between the delicate individual and the strong robust citizen. But the public health nurse is only human so she finds at times that, notwithstanding her well-laid plans and utmost endeavors, accident and disease will and do assert themselves; but even here she does not falter, for there you will find her, the practical visiting nurse, at the bedside soothing the weary sufferer, thus fulfilling, as the Duke of Devonshire so aptly styles it, the chief function of all nurses—that of bringing joy and happiness to the afflicted.

These in brief are her activities. Now what about the results achieved? In the words of one eminent authority, Lee K. Frankel, third Vice-President of the Met. Life Insurance Co., "the day has gone by when it is necessary to offer apologies for visiting nursing," and further that "this form of activity is to-day well recognized as an important factor in the im-

provement of health conditions." The United States Children's Bureau, in one of its publications, tells us that "recent years have proved that an indispensable part of any work for the welfare of babies, as well as of all public health work, is public health nursing," and adds, and mark this well, that "this service is needed in country and city alike."

The Bruchesi Institute, of Montreal, which employs the Sisters of Providence as visiting nurses, for their tubercular cases, has nothing but the highest of praise for the good work performed and the results accomplished in treating this dreaded and relentless white plague.

The Met. Life Ins. Co., which already expends annually half a million dollars in this service, is so well satisfied with all their visiting nurses throughout the United States and Canada, including our own Victorian Order, especially in maternity cases and in the treatment of the acute diseases such as pneumonia, typhoid and rheumatism, that it is making a determined effort to have this service extended to include especially the acute infectious diseases so peculiar to childhood.

And so on all along the line. In fact in all my reading I have yet to come across a single instance where the visiting nurse failed in giving adequate satisfaction.

But among all the brilliant results achieved none stand out more prominently to her credit than her lowering of infantile mortality. For instance, on this American continent, where some years ago one baby in every seven died, within its first year, now the rate is only one in ten—thanks to the activities of the public health nurse who, as one writer aptly puts it, has succeeded in changing the baby's first year from an extra hazardous occupation into that of only a hazardous one. Another instance is that of New Zealand where, since 1908, there has been a steady decline in the infant death rate until one city, Dunedin, has brought it down to 3.8, the lowest in the civilized world at the present day.

Now, far be it from me to try to belittle or decry in the least the thousand and one other efforts of preventative medicine in helping to lower infantile mortality (for I believe in giving credit where credit is due), but the point I wish to impress upon

you is this that, since the inception of visiting nursing, there has been a steady and progressive decline in the baby death rate wherever this service has been employed; and the more intensive the nursing and the greater the co-operation of the general public, the more marked has been the result, as in New Zealand where public health nursing has reached its ideal stage. Now I cannot speak for all rural municipalities, but I know that in our district, apart from other work, we could easily keep the visiting nurse busy from one year's end to the other attending solely to maternity cases, for our birth rate rivals the best in the world, but concomitant with this, our infant death rate is at times very excessive; and, to combat this, I make this my most earnest appeal to some visiting nurse association to throw in their lot with us, for such help is certainly and surely needed in our territory.

Now you might ask me if such work is feasible. My answer is that it certainly is, for the New Zealand nurse covers even the remotest country districts, whilst the American Red Cross Society is already prepared to furnish visiting nurses for every rural community. And what the New Zealand and American nurses have succeeded in doing I have the utmost confidence that our Canadian nurse can likewise accomplish, for, as Surgeon-General Jones, C.E.F., says: "The efficiency of the Canadian nurse is recognized by all as second to none in any part of the globe."

A DICTIONARY OF ALTITUDES

THE Commission of Conservation, at Ottawa, recently issued a very important volume entitled "A Dictionary of Altitudes," giving a large amount of information in reference to climatic conditions in different altitudes throughout Canada. Such information is very important to medical practitioners, placing them in a position to advise patients as to a possible effect upon their health of a change in residence from one location to another. A copy of this dictionary may be obtained by medical men free of charge, all they have to do being to forward a request to the Commission of Conservation at Ottawa. We are satisfied that a number of physicians will be glad to take advantage of the fact that polyvalent vaccines rapidly stimulate the metabolism and defense of the body, with a resultant prompt recovery in general acute infections.

Laboratories of G. H. Sherman, M.D., Detroit, U.S.A.

THE ART OF THE THERAPEUTIST.

It is pleasant to think of therapeutics as an art rather than as a cold science. The thought suggests the mature artist who, through the medium of a few well-chosen tints, is capable of giving expression to his fancy or his emotions. To the ingenuity of the artist may be likened that of the therapist who selects his agents with consummate skill. He applies them deftly, here and there, as the artist touches the canvas with his pencil, with results that are definite because he has in mind a definite plan of procedure. Even the selection of a simple laxative—Pill Alophen, for example—is not a haphazard act, but entails the exercise of judgment and skill based upon experience and a comprehensive knowledge of physiology and therapeutics. The physician skilled in his art clearly sees certain indications for Pill Alophen—the necessity of relieving an over-distended colon with the least possible disturbance of a delicate organism, perhaps. Its action is mild, gentle, yet thoroughly efficient.

THE HOSPITAL WORLD
THE MEANING OF POWDERED MILK.

BY BENJAMIN APTHORP GOULD.

I often wonder how many people realize the inner meaning of the work we are doing and what it is going to mean to the future of the world. It is much more than a mere commercial undertaking, and the fact that we are building up a successful business is only one part of the satisfaction of accomplishment. Ever since I have been in this game of ours. I have had two great ideals of accomplishment before my eyes, and now I feel that we have come within sight of success for both of them. To reach the final and entire achievement of them will take many years, but this achievement now looks to be certain, and only its time in doubt. This time we can bring nearer to us by energy and intelligence, and the work of every one in our organization can serve to quicken the rate of our progress. The first of these great ideals has been the successful solution of the milk problem of great cities. We all know that this problem is one of the most important and most difficult questions of modern civilization. Few things concern so intimately the health and happiness of hundreds of millions of people. The future of our world depends upon the children who are being born and growing up to take their share in the work of the world, and nothing affects more closely their ability to do this work than the start they get in health. We are all built up from the food we live upon, and of all foods the most important and the most dangerous is milk. Without it, the child can hardly be brought up at all, and even after infancy it is perhaps the most important food of every one of us. Nothing has done more to lessen the death rate, especially the tragic death rate of the past among infants, than have improvements in the milk supply. The very qualities which have made milk so necessary have made it dangerous, because it contains all the food values which make it an almost ideal medium for the growth of bacteria and germs. A contaminated milk supply carries in its train death, sorrow and misery. Sanitary regulations may protect, pasteurization may protect, the prohibition of the sale of loose milk may protect, and these things have saved more lives than the Great War cost. But so long as milk

comes to the consumer in liquid form these are only protections and not guarantees of safety. A careless dealer, a dirty bottle, an ignorant mother, and death enters the house and another life is sacrificed. All the complicated mechanisms of collection and distribution, the dairies at the farms, the cans and the wagons, the milk trains reaching out hundreds of miles from the cities, the great plants for pasteurizing and bottling, the early morning milkman, the refrigerator in the home, all these things are expensive and difficult steps to secure a milk supply which can never be as safe, as abundant or as cheap as is required by society.

All these troubles are inherent in liquid milk because it is bulky and because under ordinary conditions it will not keep. The countless billions of bacteria about us are always on the alert, looking for some chance made by carelessness or ignorance to pollute the milk. And without laboratory examination we often cannot tell whether the milk has been polluted, and we believe we are safe when we are in danger. The ideal toward which we have been working has been to change milk from something subject to the difficulties I have mentioned into a staple; into a food as safe and as convenient as our bread or our sugar; into something not dependent upon local conditions for its production and upon immediate use in its consumption, but something which can be produced at the time and place of best supply and used at the place and time of greatest need. None of the valuable qualities may be changed or altered; it must be milk when used as it must have been milk when it was drawn from the cow. Many people have dreamed of accomplishing this, but, until we developed our processes for taking milk directly from the farm and reducing it to a powder so dry that bacteria cannot multiply in it, there has been no prospect of attaining our end. But now we have done this, and complete success is in sight. There is much still to be done, both in perfecting our methods and processes and overcoming the minor defects in the product incident to new ways, and in providing for an adequate volume of production and an adequate instruction of the consuming public as to its advantages and the best methods of using it. But the main work has been done; we have proved our proposition and now need only to develop and perfect it. Few people realize the difficulties we have had to overcome and the variety of problems we have had

to solve, problems chemical and bacteriological, problems physical and mechanical, problems commercial and financial, problems of production and of marketing, problems of the psychology of the farmer who grows the milk and the operator who manufactures it and the consumer who uses it. The other great ideal toward which we have been striving is the solution of the milk question for tropical and semi-tropical countries. The work of men like McCollum has proved that there is no adequate source of the vitamins necessary for our development other than in milk-fat. The lack of proper milk supply has made it almost impossible for us to live permanently in health and especially to bring up our children in the tropics. The Englishman in India, the American in the Philippines, has had to send his children home to be reared, and the natives themselves of such lands have mostly lacked the vigor and stamina of those races bred upon an adequate supply of milk. If I am not greatly mistaken, the work which we have been doing will within a measurable term of years result in opening one-half of the habitable globe to the permanent occupation of men of our race, and in making an extraordinary regeneration and improvement in the physical and consequent mental condition of native inhabitants. Who can say that there are no ideals or sentiment in business? Is not the work we are endeavoring to do as big, as important, as fascinating as any which men have ever attempted? We have had imagination, we have yielded ourselves to its witcheries, and the unscaled peaks to which it is leading us are marvellous in their beauty and their promise.

The above is from an address by the President of Canadian Milk Products, Limited, to the Sales and Production Staffs. It struck our Sales Department that it was such a cry of inspiration to them that it might likewise interest some of those who are using our goods.

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ONE of the interesting things about cocoa is its color, and it is one test for purity that the housekeeper can easily apply by purchasing a can of Baker's Breakfast Cocoa and noting carefully its rich, red brown color. This is the natural color of high grade cocoa beans unchanged by the action of chemicals. When cocoa has been subjected to the chemical or so-called "Dutch" process it takes on a much darker color, sometimes nearly black.

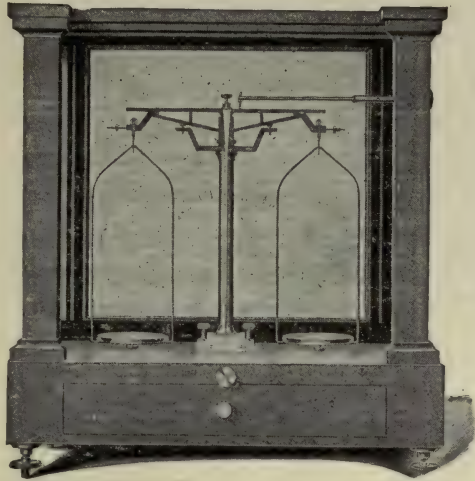
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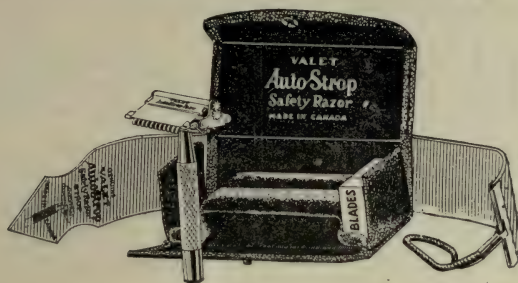
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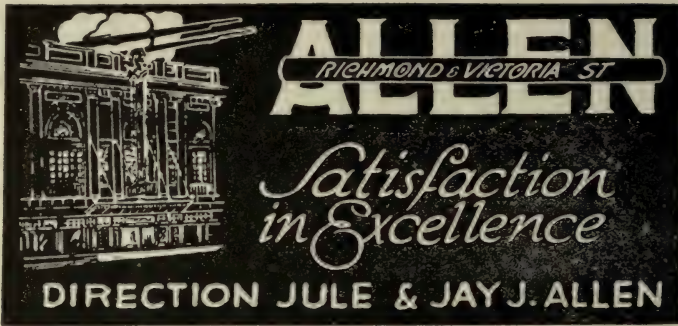
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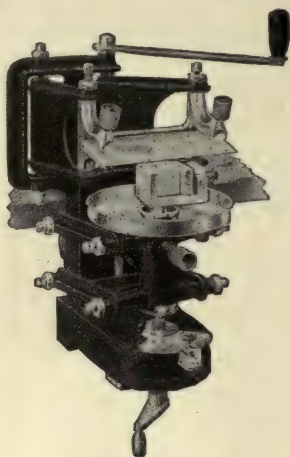
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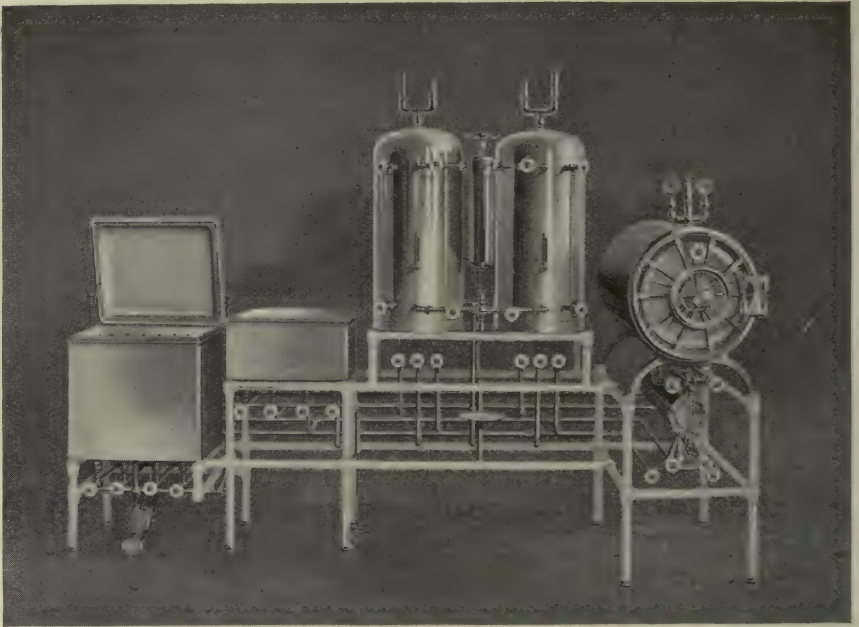
We experimented and were amazed at the find. It was that we could at one sweep add 20% more mileage to Dunlop Fabric Tires and make them last longer than Fabric Tires were ever known to last. Result: Dunlop "Cord"-built Fabric Tires are giving some other makes of Cord Tires a run for their money at, of course, much lower first costs.

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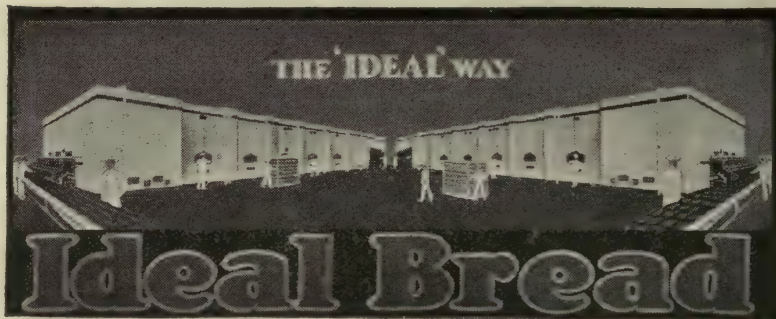
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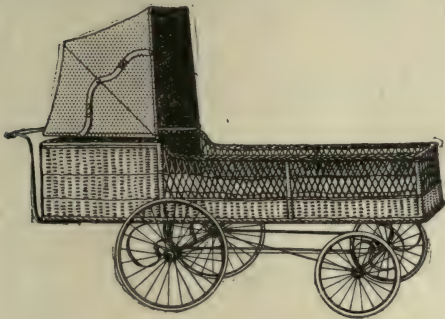
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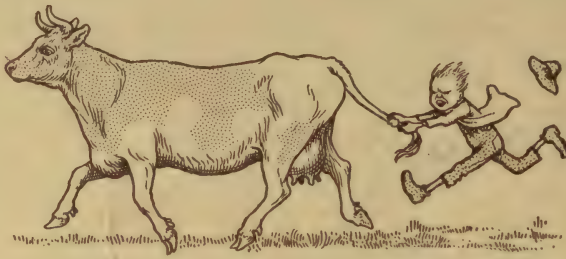


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Vol. XX

Toronto, September 1921

No. 3

CONTENTS

EDITORIALS

	Page
By Way of Apology	63
Boots and Shoes	63
Women's Dress	64

ORIGINAL CONTRIBUTIONS

Address to Nursing Graduates Wellesley Hospital, Dr. G. E. Brewer	65
B. C. Hospitals Seek Aid	70

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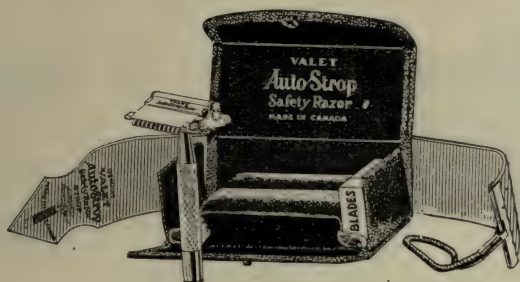
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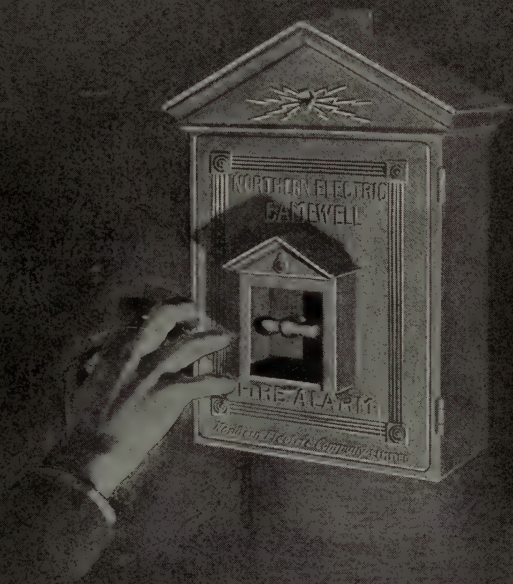
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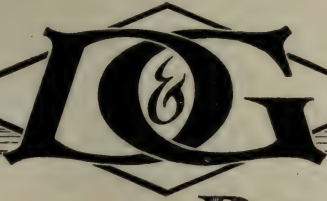
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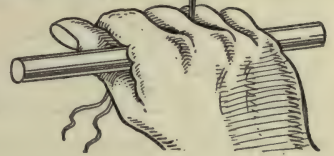
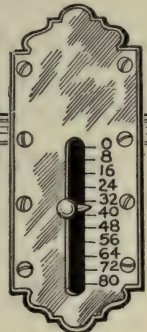
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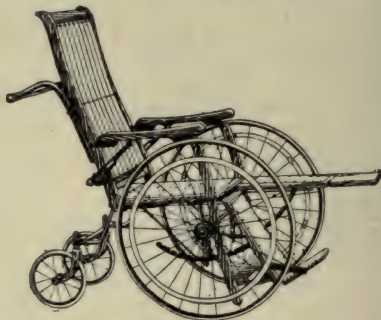
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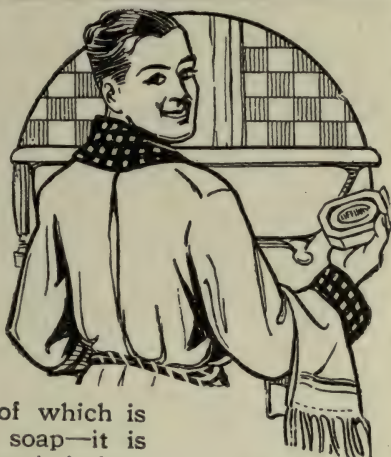
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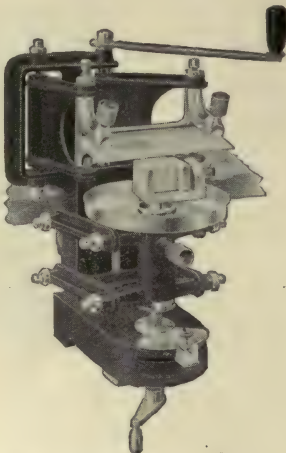
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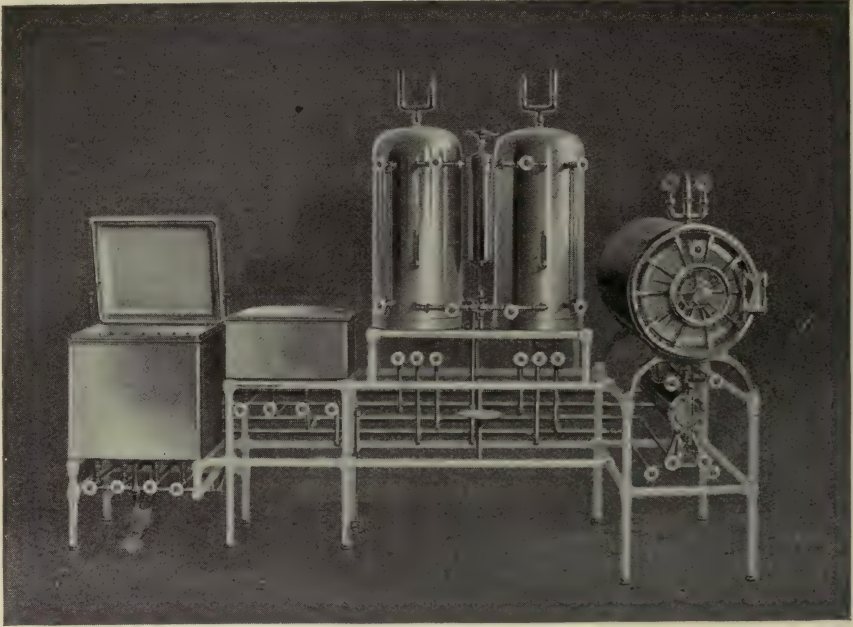
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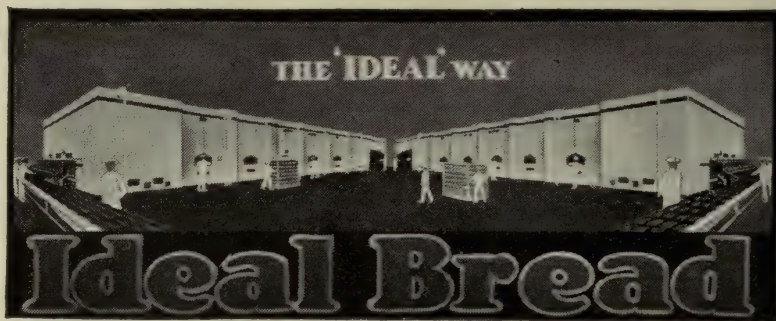
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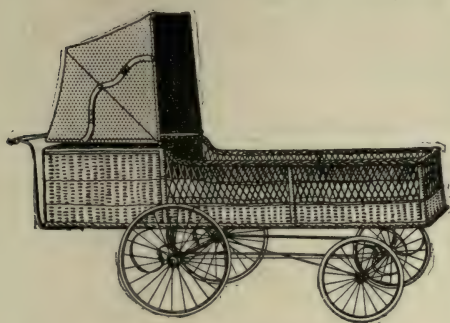
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The Hospital World

TORONTO, CANADA

**A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire**

Vol. XX

TORONTO, SEPTEMBER, 1921

No. 3

Editorials

BY WAY OF APOLOGY

THE prolonged printers' strike in Toronto has caused untold trouble to many publishers. The Firm which has always printed this journal has suffered like the rest. Foreseeing trouble the Managing Editor had June off press, July ready to bind and August set up before the avalanche. It was a wise move, as most medical journals were not issued at all. The Hospital World, as formerly, issued on time. But, on account of the necessity of getting all copy both for text and advertisements in advance, certain events occurring in the hospital and nursing world during June, July and August could not possibly be reported or made not of. Under the circumstances our readers and advertisers must and will (we believe) excuse these omissions.

BOOTS AND SHOES

AS a man climbs the hill of prosperity he dresses better and better. The last thing to receive attention, says a popular novelist, is the boots.

Our returned soldiers show their good sense in wearing sensible boots—heavy strong, boots with wide soles and

low broad heels; often, too, with rubber pads which keeps them out of the damp and obtunds the shock when the raised foot strikes the hard pavement. We are pleased to see, too, the shoes nurses wear—shoes of a similar conformity.

But one is pained to see the ridiculous shoes worn by the average girl and woman, with high French heels and narrow toes. What a sorry spectacle they present as they titivate along the sidewalks. Often one sees the heel slant over, giving the ankle a strain. What comfort can there be in wearing such miserable contraptions as foot gear? Slaves to fashion!

Every physician should be a decrrier of these foot contorters and agony producers; and an advocate for the sensible boot for women.

WOMEN'S DRESS

THE abbreviated skirt came up recently for discussion in the London Conference of the Methodist Church.

The Literar Digest in a recent number gave a compilation of the answers to a questionnaire sent to many educationists and preachers. The concensus of opinion was that the modern dress is too short.

Will Irwin in an interview with a certain celebrated woman quoted her as saying that the women will lengthen their dresses as soon as men demand it.

An agitation was raised in Toronto a few years ago to have the steps of street cars lowered. The high steps compelled an immodest exposure of the nether limbs of the fair sex. The steps of the cars had not long been lowered when the ladies shortened their skirst very much.

The flivvers used to frighten the horses very much. Now they whinny with satisfaction as they see the autos with their former burdens approach.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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Original Contribution

ADDRESS TO NURSING GRADUATES WELLESLEY HOSPITAL, TORONTO, 1921

By DR. G. E. BREWER, Consulting Surgeon of the
Presbyterian Hospital, New York.

When I received the invitation from your superintendent to come here and address a group of young lady graduates of the Training School, I must confess that I accepted with considerable diffidence and no small measure of hesitation. In one of Kipling's poems, run these lines:—

“Four things greater than all things are
Women and horses, and power and war.”

In the past my addresses have been limited almost entirely to medical students—mere men. But I feel that I have known something of medical students. I think that I have some knowledge of their character, of their aims, their difficulties and problems, and I have felt at times that I might give them some advice, and I have been pretty frank with them; I have been accustomed to tell my graduating classes in the Medical School that but few of the men seated before me will achieve great success; a few will have to admit at the end of their professional careers dismal failures, and the success of others will be midway between this extreme. So I say to you young ladies: some of you will meet with great success in your professional work, and others will undoubtedly meet with failure; others of you will also be midway between these extremes.

Now as I look into your faces, it seems to me I see there great enthusiasm; I see health; I see energy. It seems to me that I see in your countenances a desire to go forward in your professional work and place in it every ounce of energy that you possess. Success in the nursing profession, however, is only attained by hard work and by a steadiness of purpose which makes it incumbent upon you to make it indeed your life work.

Owen Meredith I think it was who said:

“The man who seeks one thing in life and but one
May hope to achieve it before life be done,
But he who seeks it from all things around him,
Only reaps a harvest of barren regrets.”

Now what can you make of your professional work? I know of no better example for you to follow than the example of the first of great women of this country who placed professional nursing on its present footing. It was my privilege some time ago to read a biography of the life of Florence Nightingale, and a short resume of it may be of interest to you.

Florence Nightingale was born in 1820, of a distinguished Hampshire family. Two striking qualities manifested themselves in her early girlhood, great sympathy for human suffering and a love of man and animals. It was well known that when there was an injured or sick animal on her father's estate, this young girl was the first to go to render aid; and in sickness and trouble she rendered solace and sympathy beyond her years. As she advanced in life this became more and more apparent, and when finally she went to London to be presented at Court, her friends found that she was wholly disinterested in social functions, but she spent the major part of her time going to hospitals, orphan asylums and Homes for the Aged to find out personally what attention they were getting. After that she went back to her home, then took a course in nursing on the Continent. She spent six or eight months in Berlin and some time in Paris, that great centre of Medicine. Then she returned to London and organized a Training School, and put into practice there, for the first time, ideas of modern nursing, and in a very short time it was recognized as a great advance over anything that had ever been known.

It was in 1854, I think, during the Crimean War, when all England was shaken by the news which came from the front of the great suffering and the inadequate supply of hospital supplies and nurses. Florence Nightingale immediately went to the Minister of War and volunteered to go out to the theatre of action with 27 nurses of her own choosing. Her offer was accepted, and she arrived just in time to receive a large mass of wounded from the Battle of Balaclava. She found not even a sufficient number of hospital beds. So far as the Medical Department went, it was entirely inadequate, and through her tremendous efforts at Headquarters she was able, during the course of a few months, to entirely change the complexion of the medical aspect. Her efforts met with discouragement time and time again through the red tape at Headquarters and

it was only through the direct order of the Minister of War and the Queen that she was able to have medical supplies sent. Her indomitable will and the enforcing of her personality upon the authorities enabled her to do the work which she did. During the war she reduced the death rate from casualties for 37% to 2%. The gratitude of England was unbounded. The Government felt that it owed her a tremendous debt, and they even made an attempt to show that by ordering her home on a Man-of-War and planning a large reception for her. Being naturally modest, she refused. She returned to her home in Hampshire quietly.

After that she established the Florence Nightingale Training School for Nurses in connection with St. Thomas Hospital, London.

In her later life she received every honor from her Government. She was called into consultation during the Civil War of America, the Franco-Prussian War, in fact every war which occurred during her life time after the Crimea.

I have given you this short outline of her character because it seems to me that there was a woman above all women of her age, who made a conspicuous professional success. And she did it, why?

- She had: 1st, keen intelligence;
- 2nd, a superlative amount of human sympathy;
- 3rd, steadfastness of purpose;
- 4th, unselfish devotion to duty, and
- 5th, Courage—

those elements which always spell success in any walk of human activity. And in times of great stress, in war, and in great national calamities, in the nursing profession, those elements are what spell devotion to duty and a heroism which is sometimes unbounded in its extent.

Although we have numerous examples of true heroism and devotion to duty in civil life, it was perhaps during the late war that we were more impressed with it because so many examples occurred on the battlefields of Europe—the Canadian nurses particularly, and the British and the American nurses who went out there and did their duty. I will cite one or two examples which will perhaps give you the same inspiration that they did all of us who saw it.

It was in July, 1918, just before the last German drive, I happened to be stationed with the Fourth French Army, with one division of American soldiers, and we had ad-

vanced to the front lines. We had organized a 1500 bed hospital very near the front. We had thirty nurses with us. All of those thirty nurses knew when they went up to that advanced position that they would be in imminent danger. It was a few minutes of twelve one day when a barrage started and within ten minutes of the time large explosive shells started to come over near the hospital. That bombardment kept up from twelve to seven o'clock. Within a few minutes of the starting of that bombardment, those nurses were placed at their various posts of duty. The work went on like clock work, the ambulances came in with their loads of wounded, great numbers of patients were distributed in the various wards, and operating work went on—and those nurses kept on duty without the slightest sign of lack of self-control. About three o'clock another explosion occurred, just to the north of the hospital and we recognized that was another gun, but instead of passing outside of the hospital grounds, we finally recognized that it was coming directly over the hospital. Still none of those nurses showed the slightest fear or anxiety. Everybody was working to capacity. The patients were coming in so fast that even with our 18-team capacity we could not keep up with it. And later we had a shell explode right in the operating ward. With what result you can understand! A minute or two after that another shell exploded between that ward and the shock ward, blowing away a part of that.

The order came: All patients should be taken underground. Fortunately we were equipped to do this. Another order came: All nurses go underground. When a count was taken of the nurses two were missing, and upon making enquiry these two nurses were found in the shock wards ministering to the patients left. They, too, were ordered underground, but they said: We can't go, who will care for these men? The medical officer took them by the hand and made them go down. A few minutes after they were again missing, and were again found ministering to the few patients who were left. This hospital was hit seven times in 35 minutes, and still not one single nurse failed to do her full duty. The bombardments continued until about seven o'clock. Orders came to move back 20 kilometers to another hospital. The patients were taken back, and the nurses were put into trucks, and as they put their little kit bags into that truck, they sang a

song. An old French officer who was standing there, with a tear in his eye, said, never before had he seen such heroism as was displayed by those devoted women.

That was not all. The next night, 20 kilometers in the rear, they were all gathered together. Everyone was working at high speed. The next night there was not much disturbance. The fourth night an enemy airplane came and fired their machine guns through the tops of our tents. The fifth night the same. And during all those five nights not one single nurse failed to report for duty. I think it was an inspiration for every man connected with that company. Those nurses had the qualities I spoke of in connection with Florence Nightingale.

Now the heroism was not all at the front. There was also a great deal manifested at the rear. It was one of our large hospitals centered at Bonne where we had 15,000 beds, during the Battle of the Argonne when beds were filled to capacity with influenza and wounded. I happened one evening that a friend of mine, a Red Cross man, went into one of the wards, and just as he went in, he saw a nurse as she was walking across the ward, she tottered and almost fell. He spoke to a medical officer, who said to her: "What is the matter, you are not well, you must report." She said: "I am not going to report; who is to look after these men if I report?" He took her in hand and found she was burning with fever. Her temperature was 105, and she was dead the next day. That woman had worked day after day with this deadly influenza germ in her and never asked for relief.

That gives one an idea of the inspiration passed on to those dough boys. To many of them that was the first opportunity they had ever had of seeing such wonderful devotion to duty, of such high ideals, and it could not fail to leave its impression upon our men who were over there.

Young ladies, the profession that you have chosen is an honorable one. Its ideals are the highest, its traditions and accomplishments worthy of the greatest place. But the path to success is not always an easy one. You will meet with discouragement and disappointments. Criticism will be handed out to you, often unmerited, but in the midst of your discouragement keep forever your ideal before you that no matter what happens you will "do your bit" for the relief of suffering humanity.

B. C. HOSPITALS SEEK AID

By H. C. Wrinch, M.D., Medical Superintendent Hazelton,
B.C., Hospital, and President British Columbia
Hospital Association.

The summarizing of the work and results for 1920 has brought to light in an unmistakable manner the fact that the financial condition of the hospitals of the Province of British Columbia have reached a crisis that can no longer be ignored. Many hospitals found themselves with a heavy deficit that had been gradually increasing in spite of every reasonable effort to avoid it. In many cases special appeals had been made during the year. Charges had been increased to the point where any further increase would react in preventing people using the hospitals. In fact it was the expressed opinion of some hospital executives that already the cost was keeping some patients out of the hospitals where they felt they would have gone had they been financially able.

Some hospitals reported having kept their expenditure down to the level of the income, but it had been accomplished only by refraining from spending for anything but actual hand-to-mouth maintenance. Needed equipment, extension of buildings, and even repairs necessary to avoid deterioration of buildings and plant, had all been denied or neglected, solely because of the treasury being continually drained to meet current maintenance and because further credit could not be obtained from banks and tradesmen.

One large hospital had so exhausted its credit that its milk dealer demanded personal guarantee from private members of the board of management or supply would be stopped.

In view of this situation the Executive Committee of the Provincial Hospital Association invited all hospitals to send representations to a special meeting for the purpose of considering the financial situation.

This gathering met in Victoria, February 11, and after a very thorough canvass of the whole situation decided to present a frank statement of the case to the government of the province, showing that the only reasonable and permanent solution would be to provide for up-keep and maintenance of all public hospitals by means of a general tax

for hospitals to be collected through usual government channels.

The Hospital Association on request was granted an audience by the Premier and Executive Council February 12, when memorial was presented; that after reciting the grave condition of institutions and their pressing needs, concluded:

"We, the British Columbia Hospital Association respectfully turn to your honorable body with the following proposals as the only reasonable solution of our problems:

"Firstly.—That the Provincial Government be requested to disburse forthwith the deficits of the public hospitals in British Columbia until such time as a better and more permanent financial policy for financing said hospitals be adopted;

"Secondly.—That the present scale of per capita grants from the Provincial Government be doubled until such time as a measure is brought in providing for a more permanent and adequate system of financing hospitals;

"Thirdly.—That the Government be requested to bring in a measure at the very earliest opportunity to provide by a universal basis of taxation for the adequate financing of all hospitals receiving aid under the 'Hospital Act.'"

The Premier in reply recognized the urgency of the need, and, while not in a position at the moment to state definitely what would be done, gave the delegation the assurance that the executive would give early and careful consideration to the matter. He expressed the opinion that, whatever the amount of relief or assistance might be, it should be provincial in scope rather than make each municipality, or other delimited district, responsible for the hospital or hospitals within its territory.—Hospital Management.

Hospital Items

ENGLISH HOSPITAL PROGRESS

THERE exists in England a Medico-Political Union with "The Medical World" as its organ.

The Council of the Union appointed a commission to inquire into the circumstances attending the establishment of a certain municipal hospital at Bradford. The existing condition had arisen through lack of accommodation at the voluntary hospital.

"The Medical Officer" says that the attitude of the Union should be made quite clear. The question of the provision of municipal hospitals is one which is going to affect the relations of medical officers of health, and general practitioners, in the future conduct of the work of both. It is of the utmost importance therefore that at this early stage the greatest amount of publicity should be given to the views of each. It is only in this way that misunderstandings can be avoided.

The policy of the Medico-Political Union is now said to be as follows (we quote from the Medical World of 4th March, the organ of the Union) :—

That the Medico-Political Union is of the opinion that the attitude of practitioners towards any given hospital should be decided by the extent to which principles approved by the profession are in operation and in no way according to the source or method of administration of the hospital funds.

The Commission suggested that the policy of the Union with regard to municipal hospitals should be similar to that adopted towards voluntary hospitals, and should be:—

(a) That there should be no countenance of the present system whereby hospitals are staffed only by those who hold the higher qualifications of one or other of the Royal Colleges or possess a university degree.

(b) That all hospitals except those which confine their activities to specialist services beyond the scope of the average practitioner should admit any practitioner who wishes to avail himself of the right to treat his own patients in hospital, but that none should be debarred because he is in general practice from any special hospital appointment to which he can devote the time and skill required.

(c) That special general practitioner wards be set apart in many existing hospitals.

(d) That the medical staff of hospitals be given the fullest possible authority in all medical questions, including dieting, nursing, etc., but claim no control of the collection or administration of funds, nor are in any way concerned as to the nature of the body responsible for the proper maintenance of the hospital.

"We recognise," say the Commissioners, "that much further consideration than we have yet been able to give is due to these considerations, but we believe that the above must prove generally acceptable in principle, and we hope that the Union will give every assistance to hospital authorities, whether voluntary or municipal, or to practitioners who are desirous of furthering the aims set forth above."

ANAESTHESIA SINGULARLY HONORED

The greatest honor and distinction recently paid the specialty of anaesthesia and the specialists in anaesthesia has been the visit of Dr. H. Edmund G. Boyle, O.B.E., M.R.C.S., of London, England, as official Representative of the Royal Society of Medicine to the Joint Meeting of the Canadian, Interstate and New York Anaesthetists with the Ontario Medical Association at Niagara Falls, and to the Joint Meeting of the American Anaesthetists with the American Medical Association at Boston.

Dr. Boyle is Anaesthetist to and Lecturer on Anaesthesia at St. Bartholomews Hospital, London. He proved to be not only a very splendid and delightful type of the English gentleman but also a very worthy descendant in that long line of pre-eminent anaesthetists founded by John Snow.

The most important message which Dr. Boyle brought to the several meetings was that about the new anaesthetic ethanesal, developed recently by one of his associates at St. Bartholomews,—Dr. R. L. Mackenzie Wallis, a noted chemist of London. During the war Dr. Wallis was in service in India and his efforts to provide the medical service with a purified and improved ether resulted in the development of ethanesal.

Dr. Boyle presented his views on and his experiences with nitrous oxide-oxygen anaesthesia and its combination to the Canadian, New York and Interstate Anaesthetists, as well as to the Nose, Throat Section of the Ontario Medical Association and also before the overflow meeting of the Anaesthesia Session of the Section of Miscellaneous topics for the American Medical Association.

During the Annual Dinner of the American Anaesthetists as well as during the banquet of the Ontario Medical Association, Dr. Boyle took occasion to express his surprise that non-medical persons were still used to give anaesthetics and he denounced the exploitation of nurses giving anaesthetics as "sweated labor." The use of nursing anaesthesia had come up for consideration after the war in England, but all concerned with public welfare had decided that no person should administer an anaesthetic not qualified to practice medicine and surgery.

Dr. Boyle was also a guest at the dinner of the American Medical Editors Association in Boston, and in his after-dinner talk he made a stirring plea to the editors present for support in the medical and dental press on behalf of the advancement of the science, practice and organization of anaesthesia as a specialty. He also urged the dental and medical schools to give far more attention than heretofore to their courses in anaesthesia. He alluded to the fact that the Royal Society of Medicine, whose Official Representative he was, had recognized anaesthesia as a section and he expressed the hope that the American Medical Association would presently take similar steps.

Dr. Boyle was accompanied by his charming wife and during their visit they were house guests of friends and anaesthetists in New York City, Long Island, Rochester, Toronto and Montreal.

NURSES ARE GRADUATED

The graduation of nurses in connection with St. Michael's Hospital, Toronto, which took place on July 6, had a special interest on account of being held in the assembly room of the splendid new nurses' home, formally opened earlier the same day.

The room, which was filled to its utmost capacity, was beautified by quantities of exquisite roses and carnations, and had it not been for the intense heat, the graduating exercises would have equalled in interest and beauty any that have taken place this year.

The program was opened by the nurses singing the "Hymn to St. Joseph," after which Miss Amy Howe sang very charmingly "Break o' Day."

His Grace, Archbishop McNeil, in addressing the graduating class, referred to the two great events of the day—the dedication of Rosary Hall and of the nurses' residence: "Catholics have today dedicated half a million dollars to the benefit of young women," said his Grace, "and this is an indication of their importance."

"The good name of St. Michael's Hospital will, in a measure, depend on your future careers as nurses and as good Christians," he continued, and, in conclusion, he exhorted the graduates to devotion to duty and independence of thought.

The diplomas were then presented by his Grace, each graduate kneeling as she accepted her certificate. Short addresses were given by Dr. Silverthorn, Dr. Julian Loudon and Father Cline, and by Dr. Walter McKeown, who acted as Chairman.

The program concluded with the nurses singing a chorus, "O, Canada," the music and the words of which were composed by one of the Sisters of St. Michael's.

The following were the graduates: Miss Hilda Kerr, Miss Grace Moyer, Miss Rita Woods, Miss Teresa Huntley, Miss Margaret Blackall, Miss Beatrice Dunnigan, Miss Agnes McCabe, Miss Lulu Marrin, Miss Kate McGuinness, Miss Hazel Charlebois, Miss Helena Maddell, Miss Anna James, Miss Venita O'Connor, Miss Anna Sheridan, Miss Elfreda Rumball, Miss Mary Loy, Miss Minnie Wadderton,

Miss Annie Loftus, Miss Mary Keaney, Miss Eileen Rior-don, Miss Hilda Holmes, Mrs. Tilley Sharley, Mrs. Beatrice Gough, Miss Florence Dwan, Miss Louise Quinlan, Miss May Mullins, Miss Anita McInnis, Miss Amy Howe, Miss Irene Gaudet and Miss Mamie Terrio.

FORMAL OPENING OF COMFORTABLE RESIDENCE AT ST. MICHAEL'S HOSPITAL

The wide regard and interest which obtains in health as well as in illness for those who minister to the sick was evidenced by the large numbers who inspected the splendid residence for nurses of St. Michael's Hospital on the occasion of its formal opening on July 6.

The building is of seven stories, with accommodation for 150 nurses. The brightness, beauty and comfort of its plan, appointments and equipments excited the unqualified admiration of all visitors.

On the main floor, to the right of the entrance, is a reception room, decorated and furnished with a charming effect of blending grey and blue. Adjoining this is the library, and over the connecting archway is an impressive etching in brass by Mr. J. E. Laur. This depicts a Sister of Charity ministering to the wounded on the battlefield, and is from a picture of an actual incident in the American Civil War, where a nursing sister was inadvertently shot.

Among other pictures in the reception room is a fine portrait of His Grace Archbishop Neil McNeil, painted in oils by Mr. Merritt Maloney.

The library is decorated in quiet hues and banked with book shelves.

The floors above are taken up with bedrooms, some of which are double, calculated to please two Sisters or very close friends among the nurses. All the bedrooms are comfortably furnished. On the third and fourth floors are rest rooms. There is a room on each floor reserved for cases of illness, and for the same contingency a kitchenette is equipped in the basement.

A roof garden extends over the entire top of the building. In the basement are large gymnasium and recreation rooms, and on the main floor the lecture room and class-rooms. A self-operating elevator is another modern convenience of the residence.

The operating suite recently built on top of the hospital itself was also formally opened July 6. This latest acquisition of the hospital is fitted up almost entirely of white tile, very bright from the light which floods through large windows on every side. It consists of five operating rooms, the equipment and facilities of which are among the finest and most modern in Canada. There is, for instance, a completely equipped sterilizing room, and everything, both in and out of the operating rooms, is ordered for the convenience of the surgeons.

The formal opening took place when his Grace Archbishop McNeil blessed the operating rooms and nurses' residence. In the lecture room of the latter at 9 o'clock Mass was celebrated by his Grace, assisted by Rev. Father Sneath and Father Kehoe.

NURSES GRADUATE AT FERGUS

Three nurses of the Royal Alexandra Hospital Training School for Nurses, Fergus—Misses Frances W. Seiler, of Eden Grove; Lottie A. Brigham, of Allenford, and Bertha J. Henderson, of Kincardine—graduated on June 17th, in Melville Church, when a large number of friends were present.

The address to the graduating class was delivered by Rev. Mr. Hiltz, L.L.D. He considered the occasion one of privilege and responsibility. The graduating class have attained their goal and now have the responsibility of living up to it. Of late years the channels of service have opened up for women, but he would still declare that, apart from motherhood, there was no nobler and grander calling for women than nursing. To some people service means bondage, but to others it is freedom. The nurses have been called to service. Service is the doing of the thing that has to be done whether it is your own job or not. As noble examples he mentioned Barnardo and his work for the homeless waifs, Florence Nightengale and Abraham Lincoln.

Our service is always colored by our character, like the sun passing through a stained glass window. The motto of the Hospital is "Caritas" or Love. Our daily work is often commonplace, but if we think of it as part of the work of making the world a better place to live in, it uplifts our souls.

Have high ideals and cultivate a healthy dissatisfaction, but be contented. Do not take yourselves too seriously. Cultivate a sense of humor; be loyal to your trust; remember those who have preceded you and who hand on their work to you.

In conclusion he expressed his hearty congratulation to the graduating nurses and wished them success; he also congratulated the Lady Superintendent and the staff on their great work and hoped that their standards would continue to grow higher and higher.

Before presenting the diplomas to the nurses, Dr. Groves made a few remarks. He first mentioned the death of Mr. George Beatty, who had been a constant friend of the Royal Alexandra Hospital. He thanked the officials of Melville Church for the use of the building for that evening and the directors of the hospital for their assistance in times of difficulty, and those who worked with him, especially Mrs. Mickle and the nurses in training for their loyalty.

The Royal Alexandra Hospital at Fergus has been in existence now for almost twenty years and has taken in everyone, whether they had money or not. The number of patients taken care of has been equal to more than four times the population of Fergus—a remarkable record. No financial assistance has been sought from anywhere. When Fergus Hospital was started there was no other one north of Guelph but now there are quite a number which have been started since that time as a result of the success of the Royal Alexandra Hospital. These include Orangeville, Mount Forest, Harriston and Kincardine.

WEST END WILL HAVE GENERAL HOSPITAL

Sacred Heart Orphanage Will Be Opened for Care of Sick and Maimed

Carpenters are now at work renovating the Sacred Heart Orphanage at Sunnyside, Toronto, which is being converted into a hospital by the Sisters of St. Joseph. At the present time there is no general public hospital west of Bathurst Street, where the Western is situated, and the plan is to have this familiar building on Queen Street West turned into a hospital for the whole west end.

It is the intention to call the new institution St. Joseph's Hospital. As an orphanage it had accommodation for about 400 children, and in all probability there will be room for practically the same number of patients. For the present no additions will be made to the building, but it is expected that before long demand for accommodation will make new wings imperative. Elevators are being installed and when alterations are completed the hospital will be modern in every way.

The land has an area of little over nine acres assessed at \$114,000. The building is assessed at \$53,000, making a total on the property of \$167,000. A splendid view of the lake is commanded from the site.

The inmates of the institution were removed, the girls going to the House of Providence, and the boys to the St. John's Industrial School on Blantyre Avenue. It is nearly forty years ago since the orphanage was established.

A NEW INFIRMARY

A new Infirmary Building has been erected at the Muskoka Cottage Sanatorium. This building, which is of fire-proof construction, is complete in all its appointments and offers every comfort and convenience for patients. In addition to this, there is of course, other accomodation available at various rates as per card enclosed. The Physicians and Nurses at Gravenhurst are experienced in the treatment of patients suffering from Tuberculosis, and they have at their command modern scientific equipment.

Physicians should bear in mind that the Muskoka Cottage Sanatorium aims to give service at cost. The Institution is under Dominion Charter and is operated by a voluntary Board of Trustees, who give their services without charge: there are no dividends to be paid.

Any patients requiring private Sanatorium treatment will be pleased with the accomodation and service offered at Gravenhurst.

HOSPITAL ADDITION

The tender of the Russell Construction Company of \$142,263, for the construction of an addition to St. Joseph's Hospital, Peterboro, was accepted, and work began in July. The new building will unite the latest features in hospital construction and practically double the accommodation of the institute.

"Short Talks on Personal and Community Health," by Louis Lehrfeld, A.M., M.D., with introduction by Wilmer Krusen, M.D. Philadelphia: The F. A. Davis, Company, publishers.

This little book, consisting of 270 pages, presents the problems of Public Health in a clear, easily readable and thoroughly understandable manner. It is written in a popular style, and would be of great assistance to the students of the University and of the High Schools. Dr. Lehrfeld has explained the technical points fully, and his warnings are sufficiently strong.

The book is divided into 6 parts, dealing with (1) Preventable Diseases and how to avoid them, (2) Subjects for Spring and Summer, (3) Subjects for the Holidays, (4) Miscellaneous Topics, such as the importance of exercise, safety on streets, occupation and disease, malnutrition, etc., (5) Foods and Water, (6) Talks about Infants and Children, (7) First Aid to the Injured.

A Primer For Diabetic Patients. A brief outline of the principles of diabetic treatment, sample menus, recipes and food tables by Russell M. Wilder, M.D., May A. Foley, and Daisy Ellithorpe, Dietetians, the Mayo Clinic. Philadelphia and London: W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto, 1921. Price \$1.75 net.

For the daily instruction of patients suffering from Diabetes this was prepared by the dietetic staff at the Mayo Clinic. It tells the purpose of the diet, explains how the weighing and coloric estimations are made, etc., with varied menus.

Nurses' Manual of the Skin in Health and Disease, by L. Duncan Bulkley, A.M., M.D., Senior Physician to the New York Skin and Cancer Hospital. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1921 Price \$2.50 net.

This is a dandy little work. The story is told in Dr. Bulkley's usual felicitous style. If nurses knew all that the book contains they could almost practise medicine. If medical students read it they would pass a good exam on skin. If the general practitioner knew it he would not fall down as often as he does now on treatment of skin disease. The points on the general management of eczema of children, the local treatment of herpes; the chapters on the care of the skin, and on diet, are especially valuable. The illustrations are fine. The full directions of how treatments are applied will be found of great service.

FAITHFUL NURSES GAIN REWARDS

Citing Florence Nightingale as the flower of the nursing profession, and counselling the young graduate nurses to follow the same path of service and devotion to humanity, Dr. George Emerson Brewer, one of New York's foremost surgeons, delivered the address to the graduates on June 14th, at the seventh annual graduating exercises of the Wellesley Hospital Training School for Nurses, Toronto. The graduation ceremonies were held in the natural amphitheatre on the west lawn under the trees, a phalanx of white-robed nurses occupying the raised terrace behind the platform, while the twenty-one young graduates filled the front rows facing the speakers. Hon. Sir William Mullock, K.C.M.G., president of the board, was chairman. Miss Elizabeth Flaws, superintendent of the Hospital, gave a resume of the year's achievements, and Mrs. Herbert A. Bruche distributed the school pins and diplomas. Seven scholarships were awarded, presented by Sir Edmund Osler, Dr. Herbert A. Bruce, Sir John Eaton and Sir William Mulock. Rev. Dr. Cody conducted the devotional exercises which opened the ceremonies.

Sir William Mulock, the first speaker, referred to the rapid advances being made in the nursing profession and to the high standard of efficiency attained by the graduating nurses. The Wellesley Hospital was increasing in popularity, and the buildings were filled to overflowing. Miss Flaws, the superintendent, was rendering splendid and efficient service.

Miss Flaws, in reading the annual report, referred to the great number of applications received for entrance to the Training School. Of the 302 applications only twenty could be accepted. It was the aim of the school to fit the nurses to go out into the numerous fields indispensable to public health. Miss Flaws advocated the establishment of a course which would give the nurses their degree at the University and also their graduation diploma from the hospital. The affiliation with the Hospital for Sick Children was proving a great advantage to the Wellesley nurses. She urged the graduating class to obey the calls of duty, service and sacrifice, and to find their reward in work well done.

Following Dr. Brewer's address, which is reproduced in another part of the Journal, Mrs. Bruce presented the pins and diplomas to the graduating class. Dr. Gwyn, on behalf of Sir Edmund Osler, presented Miss May Steacy, senior division, and Miss Dorothy Powers, junior division, the Sir Edmund Osler scholarship for the senior year.



Miss Florence Pearse won the scholarship for proficiency in operating room technique, presented by Dr. Herbert Bruce. The Sir John Eaton scholarships, for general proficiency, intermediate year, presented by Mr. R. W. Eaton, were won by Miss Edith Cale, senior division, and Mrs. Barry, junior division.

The Sir William Mulock scholarships for general proficiency, junior year, were presented by the Honorable Featherston Osler to Miss Eleanor Hinch, senior division, and Miss Aileen Harrison, junior division.

The graduating class were as follows:—

Miss Ella Morton, Keswick, Ont.; Miss Waple Greaves, Barbados, B.W.I.; Miss Hilda Thompson, Elmsdale, N.S.; Miss May Steacy, Napanee, Ont.; Miss Abigail Derbyshire, Westport, Ont.; Mrs. Mary Longman, Iroquois, Ont.; Miss Nita Coulter, Port Perry, Ont.; Miss Anne Barton, Uxbridge, Ont.; Miss Jennie Lowe, Bracebridge, Ont.; Miss Dorothy Thompson, Tillsonburg, Ont.; Miss Edith Mac-Namara, Hamilton, Ont.; Miss Florence Pearse, Galt, Ont.; Miss Marjorie Hardy, Toronto, Ont.; Miss Dorothy Powers, Picton, Ont.; Miss Gertrude Stover, Iroquois Falls, Ont.; Miss Margaret MacLennan, Sault Ste. Marie, Ont.; Miss Anne McBeath, Madock, Ont.; Miss Mary Wilkins, Belleville, Ont.; Miss Jessie Joyce, Napanee, Ont.; Miss Greeta Bellman, Bowmanville, Ont.; Miss Florence Hogg, Galt, Ont.



Selected Articles



WILLIAM OSLER—A MEZZOTINT

I was transported in my dreams
While sorrow slumbered close to time.
To me once more the bells' soft chime
Came floating o'er fair brimming streams,
While all around the gentle breeze
Strewed blossoms of the flying days
On meadows steeped in summer haze
Beneath the broad and kindly trees.
Oxford with all her "brooding towers,"
Her battlements and turrets fair,
Brought back the friends who gathered there
In other days, in other hours.
And then the very air was fraught
With higher impulse and the earth
Seemed freed of pain and of its "dearth
Of nobler natures," and I thought
This place is Eden.
One man there was, the rest among
With gleaming eyes and eager tongue,
Teacher, not pedagogue, he seemed:
His laugh was such a vivid laugh
And one behind its ring could hear
The mind harmonious and clear,
The human heart beneath the chaff.
Master of all, true knight and bold:
A thing to marvel at and prize
That one so learned, was so wise.
We hearkened to his words of gold
And wandered to his treasure-room,

The sacred spot where that great mind
Dowered its riches on mankind.
There in the twilight's deepening gloom
We wondered how one brain could know
All that he knew of Truth. . . . and more.
We saw his leathered tomes a-row
And as we conned the titles o'er
We found the Aesculapian art
Usurped not all the books, but some,
Those marked most with a loving thumb,
Displayed upon them names more sweet,
While deep within their pages bloomed
The flowers of bye-gone days—perfumed.
And some there were that seemed to treat
With odorous words of thoughts divine
From souls of English bards outpoured.
Not far aloof, a treasured hoard
Where one could drink the potent wine
Of ancient volumes, dark with age;
There Locke, and Hooker, many more
Of varying age and varying lore,
There Richard Burton's studious page,
And in a post of honour, lo!
A gallant man whose thunderous prose
Will echo to the end of days,
Sir Thomas Browne, in splendid row.
Fifty they were, nay, sixty strong.
Then with caressing hand and voice
The Doctor took from out the throng
A single volume of his choice
And as he turned its page would read
Some solemn sentence, then would meet
Some quaint and curious conceit
Or old-time counsel of a breed
Surely immortal.
His eyes would smile at quip or jest
Before he laid the book to rest
And parted from it lovingly.

But even as he smiled it seemed
That books and book-shelves dimmer grew
And Oxford faded from the view.
Then all was changed—or so it seemed—
Behold; it was the “honeyed night”
There stood a board with goodly fare
Well freighted, formed to banish care.
The candles shed their tender light
O’er fragrant flowers, faces clear,
And this was Canada, his place
Of birth—his best-loved race—
Here all was joyous, for the seer
Was still unchanged, and still we heard
His laugh inspired, and I ween
No fanged satiric arrow keen
Or spiteful jest that laughter stirred
But shafts, all poisonless, of wit
And subtle humour that were fired
By him we fervently admired.
All those that at the feast did sit
Uplifted were, and proud to clasp
The hand of him we loved, the man
Of nobler work, of nobler plan.
’Ve felt the fine soul in his grasp,
His genius, his simplicity.
And this was our felicity
That he could cross the seas and fling
His mantle like a radiant thing
O’er those that breathe less generous air
And show this miracle, that Fate
Could make so great a man—so great,
And prove the breed our Land can bear.
The heights he climbed must be refused
To lesser men, and given to those
In whom authentic genius glows
With god-like vision. . . . so I mused
And pondered till the air was filled
With mystery. . . .

Then all was stilled.

Up through the flowing tide of dreams
My spirit swam to reach the light.

Sorrow clung close, in robes of night,
And through her veil I saw the gleams
Of crystal tears of memory.

The tears of all humanity.

Then music swept from mystic strings,
'Neath whisperings of mighty wings:

And Time whose face was as a star
Held in his hand a jewelled wreath

That every sorrowing heart beneath
Might know and worship from afar,

That every tear-dewed eye might see
His crown of immortality.

MARION OSBORNE.

THE DOCTOR'S THERE

WHEN in the cottage blessed with Love's sweet store.
A babe is born and o'er the rustic door
Is hung the crown of motherhood, and fair
Is all within—the Doctor's there.

When 'neath the pall of mystic Death's weird spell
A mother's heart is broken by the knell
Of all that's dear, and on the stair
No baby feet—the Doctor's there.

When virtue flees and breath of ruthless lust
Eats into the soul as does the gnawing rust,
When no one else with her the shame will share,
With mother's touch—the Doctor's there.

Where blossoms Life's sweet Bud at blush of day,
Where breath of withered rose at eve-tide steals away
On the South wind—in joy and care,
An uncrowned king—the Doctor's there.

L. B. McBrayer, M.D., Asheville, N.C.

THE MEDICAL OFFICER

BY R. G. H. OSBORNE.

BETWEEN the living and the dead, the Army surgeon stands,
And life, oft hanging by a thread, lies in his skilful hands;
A soldier at his country's call, he draws no faltering breath,
But fights that mightiest foe of all, the final victor, Death!

To meet so dread a foe he brings the true physician's mind,
Which holds, above all other things, the reverence for mankind:
Did his own brother wounded lie, tho' toward him he would
 speed,
He would not pass a foeman by, if his the greater need.

Within his breast, to duty true, no shrinking spirit dwelt.
Oft has he served, and fallen too, beneath the screaming shell;
The hope to succor and to save, his one ambitious thought;
If honors come to mark the brave, they come to him unsought.

To snatch from ravening Death his prey with dauntless soul he
 speeds,
And few the words he has to say—his pity speaks in deeds!
The life within him, tense and clear, from brain to finger runs,
Nor does he heed, nor even hear, the roaring of the guns!

This son of science, rarely found applauding crowds before,
For whom no trumpet-blasts resound, too many oft ignore;
Yet he, upon the storm-swept plain intent alone to save,
And wounded scorning all his pain, is bravest of the brave!

R. H. G. Osborne, Jour. Amer. Med. Asso.

In treating a patient one must think first of the general management of the case—the placing of the patient under the best possible conditions to fight the disease. Diet stood next in importance. The menu should be written down. Before ordering any particular article, one should ascertain if it agrees with the patient. No article should be forbidden, with good reason. If an article disagrees with a patient it may not be wise to cut it out altogether—especially in chronic diseases. If you do so the patient's nutrition may suffer. Any changes in the diet should be made gradually.

In respect of drugs, they may be necessary if only for psychological reasons. One should know exactly what he can do with drugs, and having made up his mind must use them boldly. Use one drug at a time, if possible. The prescription ought to be made as palatable as possible.

For instance, in prescribing a drachm of magnesium sulphate, by adding twenty minims of fluid extract of cascacia, it works faster. To prevent the griping add fifteen minims of the tincture of ginger, and to convey it pleasantly add an ounce of peppermint water.

Latterly, physical methods have been coming largely into use—massage, baths, electricity, special exercises. Climatic treatment might also be considered as a therapeutic measure.

Every big hospital should have a psycho-therapeutical department. Psycho-therapy plays an important part in all treatment. "He is the best physician who is the best inspirer of hope," said Coleridge. Suggestion cannot be taught; it is part of a man's personality—a kind of virtue that goes out of one when dealing with disease. The power of impressing on patients a belief that they are going to get well is one of the secrets of the physician's success.

THE HOSPITAL WORLD

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TREATMENT

THE old country practitioners are strong on treatment. Hutchison, of the London Hospital and medical school gave a fine lecture on the subject recently, as reported in the *Practitioner* for September, 1919.

Hutchison maintains doctors should have a definite plan of treatment, founded on what is necessary to accomplish for the relief of the patient; and one must not easily be diverted from this plan. The plan should be simple, so that the patient will not complain that the treatment is worse than the disease. No patient must be asked to do impossibilities—his financial condition must be kept in mind. The directions must be exact—better to be written down. Treat the patient, not the disease. The old family doctor made his success by following this rule, and can observe it better than a consultant or specialist can.

Systems of treatment should be avoided. The treatment must be individual. Fads, like the devil, should be avoided. Sir James Paget, one of the wisest of practitioners, held that as one grew older the more he tended to write the same prescription for everything—the beginning of faddism.

Treatment ought to be conservative. The old treatment has stood the test of time; one should be sure that the new is going to be better than the old before being adopted. One should "prove all things and hold fast to the good." We can learn something from all sorts of irregular practitioners. Treatment may be radical or symptomatic. The radical is represented by surgical measures such as opening an abscess; and the administration of quinine to kill malarial parasites. The treatment of the symptoms is comparable to the cutting down of a tree, branch by branch.

Again, treatment may be expectant—allowing nature to work the cure, the doctor standing by prepared to intervene if satisfactory progress is not made.

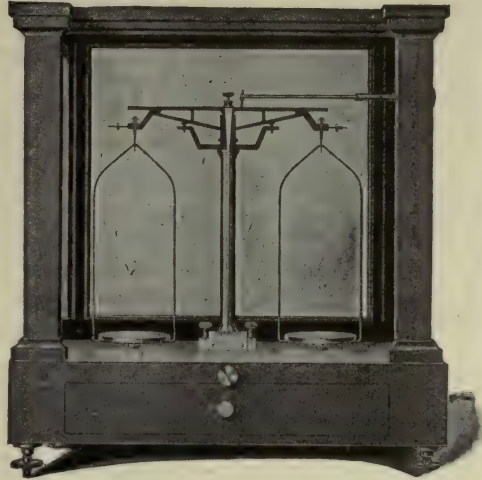
Remedies may be rational or empirical; thyroid extract, where there is a deficiency of thyroid gland, represents the former sort; the treatment of malaria by quinine was empirical until the parasite was found, when it entered the realm of rational remedies.

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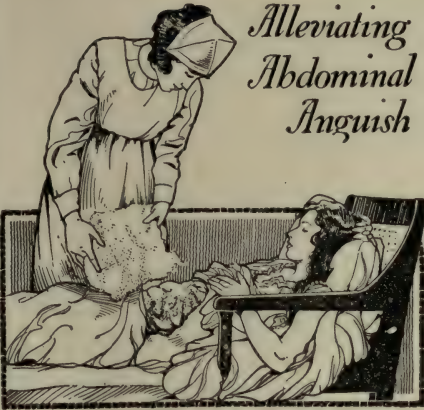
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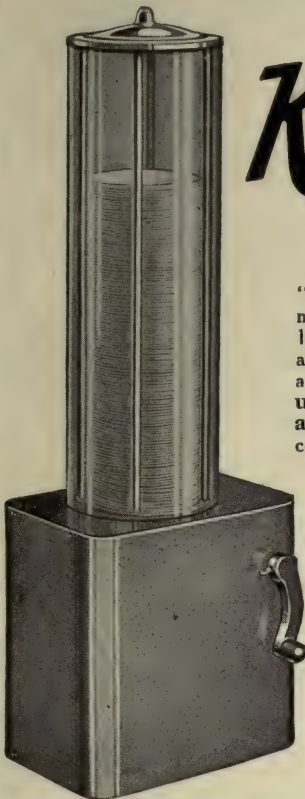
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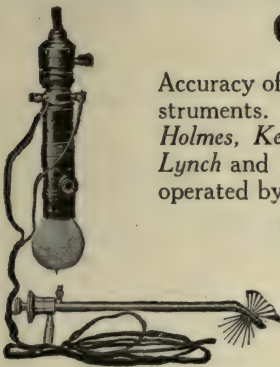
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THE HOSPITAL WORLD

Vol. XX

Toronto, October 1921

No. 4

CONTENTS

EDITORIALS

The Nursing Situation.....	Page 96
Hospital Internes.....	99

ORIGINAL CONTRIBUTIONS

The Future of Hospital and Medical Practise, J. N. E. Brown M. D.....	102
The Financing of Public Hospitals, M. T. MacEachern M. D.....	111

SOCIETY PROCEEDINGS

The British Columbia Hospital Association.....	117
--	-----

SELECTED ARTICLES

Hospital Fans who can't leave.....	127
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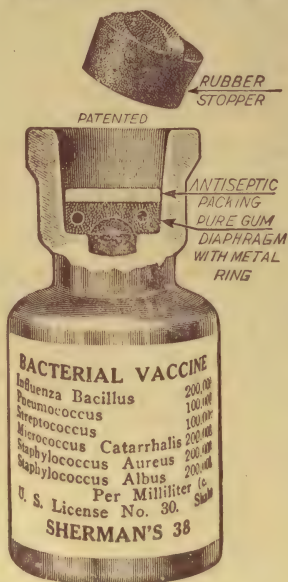
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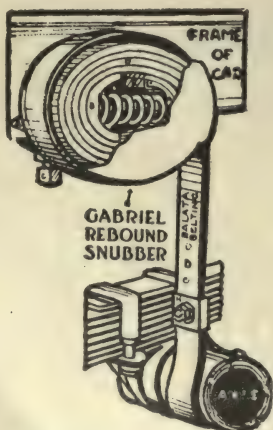
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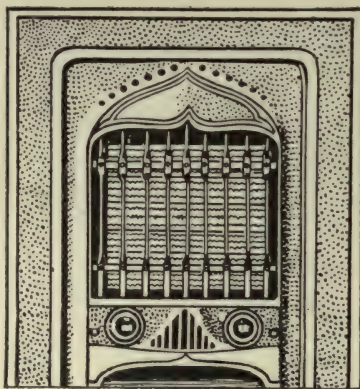
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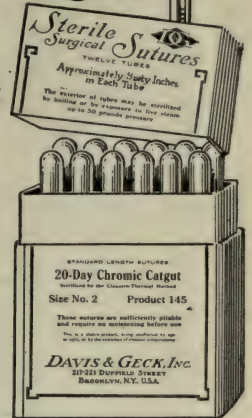


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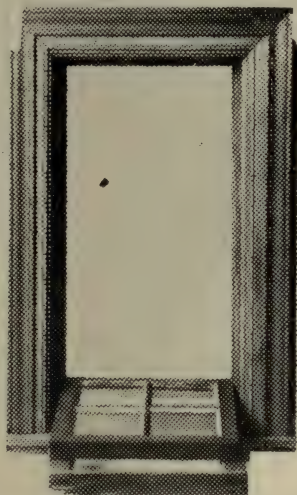
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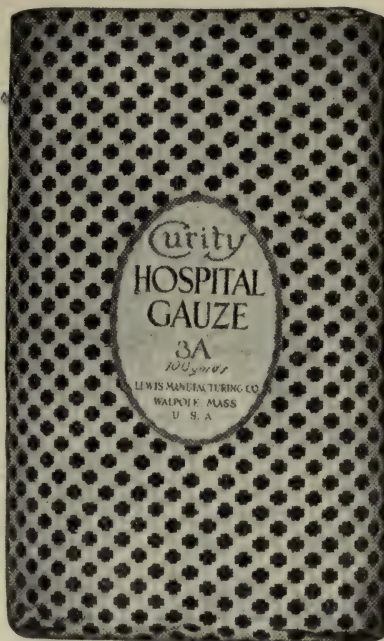
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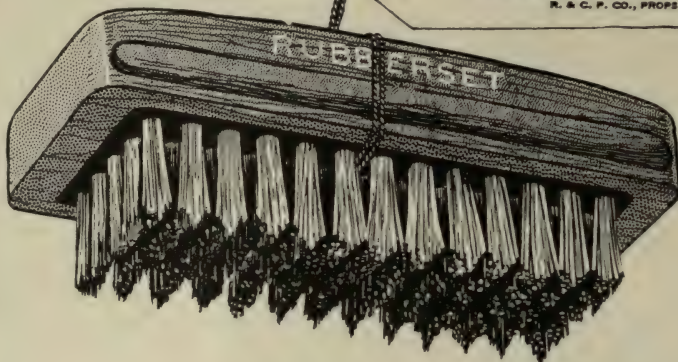
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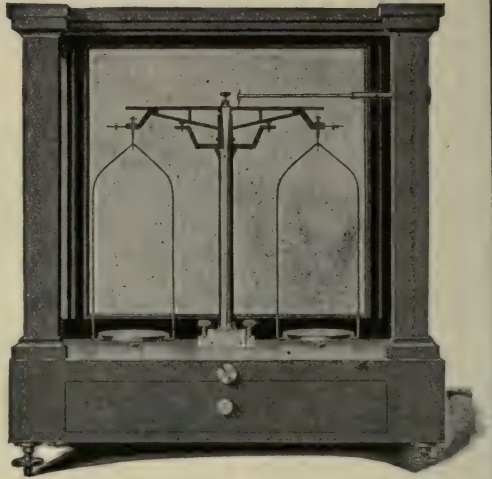
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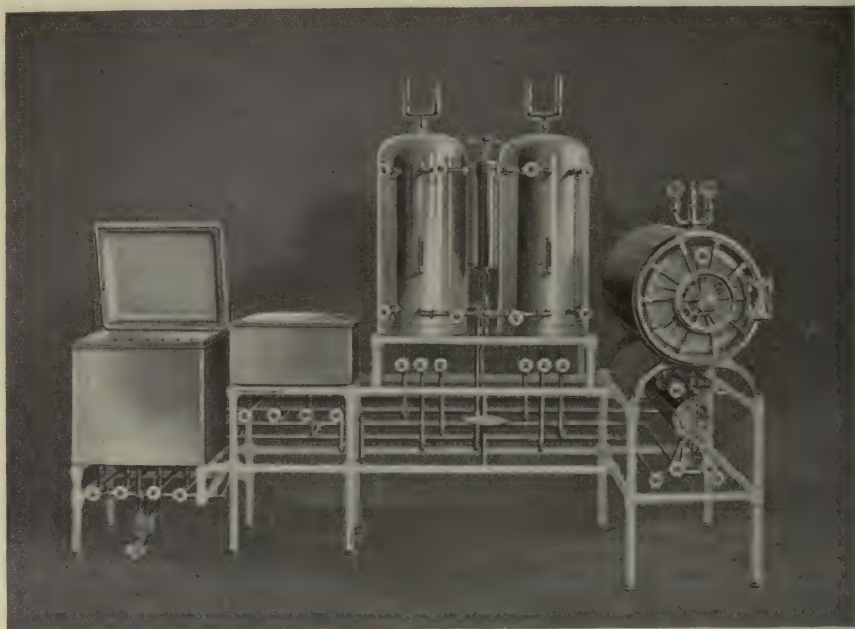
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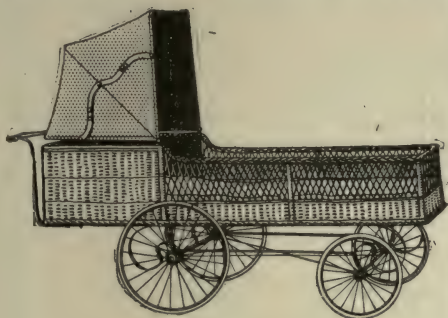
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
and Public Charitable Institutions throughout the British Empire

Oct., 1921

THE HOSPITAL WORLD

No. 4

THE NURSING SITUATION

Under this caption, Dr. Gilman Thompson, one of New York's most prominent doctors, makes a contribution to the *New York State Journal* of medicine. What he says comes with much weight because of his long connection with the hospital and nursing situation. Dr. Thompson is one of the few medical men who has taken a special interest in hospital construction and organization. In addition he has had an extensive private practise which has brought him in close contact with the domestic nursing problem.

He begins, like a careful clinician does, by inquiring, "What ails the nursing situation?"

The public cannot pay the rates asked (\$10 per day now in New York City, the writer of this is informed). Doctors are dissatisfied because they cannot get adequate nursing. The type of women formerly attracted to nursing is dissatisfied for economic and other reasons.

In the Nightingale era the patient required relief of suffering, comfort and support; now he is a "case" for observation and diagnostic research.

The attitude of the medical profession changed and more responsibility was placed on the nurse. Then followed the training school exploitation of nurses; then the era of training school legislation to protect the trained nurse in her future work from encroachment upon the field of original humanitarian service by anyone except an "R.N."—culminating in one bill for a monopoly of the term "nurse" to those only of legalized training; "any attempt to permit the so-called 'trained attendant' to obtain the advantages of a little hospital instruction, meanwhile being firmly resisted."

Then came the war era. Although trained nurses by thousands volunteered everywhere with splendid patriotism, their numbers were far inadequate, and there was no considerable group of trained attendants to meet the emergency.

Short intensive training was widely instituted, and some conservative hospitals temporarily and more or less reluctantly opened their doors for the trained attendant type. This proved the fact long realized by the medical profession, that "a young woman of ordinary ability and moderate education can be 'trained' to make a very competent general nurse, by intensive method, most emphatically within two years." The Health Commissioner of Chicago has been giving nurse attendants a two months' intensive course, and claims to have had great success with over 4,000 pupils. Dr. Thompson thinks this may be extreme, but avers, **"I know that it can be done in three months very satisfactorily, with competent pupils and competent teachers."**

Dr. Thompson states that a few years ago when it was customary to give intensive training to 'probationers' before assigning them to definite ward duty in schools with a 3-year course, he suggested in a school

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which he had helped to found, that these 3-month probationers give a public exhibition of their work; a custom subsequently widely copied, after witnessing the various bed adjustments, all sorts of bandaging, making of poultices and plasters, making records, adjusting croup kettles, giving hot pads, washing babies, etc. A medical colleague on the Visiting Staff inquired of the Superintendent of the school, "Why, Miss X., what is left for these young women to learn in the rest of their three years?"—which heartless remark was received with marked disdain!

Dr. Thompson proceeds to say that in not a few instances women trained by shorter courses have proved more satisfactory than the highly over-trained nurse who often becomes restless with simple or chronic cases, feeling, not unnaturally, that having been taught all kinds of things from electro-cardiography to voice culture, she ought to be turning her instruction to practical account.

One young woman, recently a probationer in a training school of very high standing brought her text book in anatomy. Her next lesson included a description of the splenoid bone, reproduced in a large picture. This week-old probationer was asked to learn whether there is any sodium chloride in the teeth!

The fifth era, says Thompson, is the economic period. The war took many nurses out of the country. Many of these, unsettled, have not re-entered the field. Many fields of gainful employment were opened up. The stenographer, for instance, can earn about as much as the trained nurse used to before she became a luxury for the rich only. She has shorter hours, though the eight-hour day prevails in some hospitals. She has her evenings, Sundays and holidays free and is subject to no rigid discipline during her "off" hours. She can live at home, see friends freely, go to such entertain-

ments as she likes, with whom she likes, as often as she likes, provided she does not get too sleepy to do her work accurately. The attitude of the training school, she finds, is precisely that of a young girl's boarding school, yet these women are taken only between 21 and 35. Why should she give up her freedom and spend three years studying such things as spheroid bones?

Is it any wonder, inquires Dr. Thompson, that training schools find it increasingly difficult to recruit their ranks?

Dr. Thompson claims that a nurse should be permitted to learn all she needs in a reasonably short time, and go out to earn her living. After she has become proficient in any particular procedure, it is, from her standpoint, a waste of time to go on repeating it indefinitely. The best interests of the hospital service often demands that she be kept longer at one set of tasks than she needs. It often happens she graduates without any experience in certain important methods in which her more fortunate class mate may be instructed.

It is further an undesirable feature of our training schools to turn out an A1. nurse capable of managing an operating room or a small hospital with the same recognition as one who barely manages to complete the course.

Much relief could be found by admitting a group of trained attendants to gain a moderate experience in hospital wards, thus relieving the regular hospital nurses from undue repetition of things already learned, and further by giving the "R. N." to all nurses at the end of a two years' course. Then a further certificate should be granted to those who desire to fit themselves as operating room head nurses or who attain expert knowledge of public health or industrial

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nursing, nursing the insane or tuberculous, or patients undergoing special research, welfare work, etc.

And, finally, says Dr. Thompson, "In every hospital where nurses are instructed, **the curriculum should be submitted to and under the direction of the medical staff; for it is due very largely to the inertia of the medical profession that so much dissatisfaction with present methods exists.** Training school superintendents will find their task much easier if they will take a broadly comprehensive view of the entire economic situation, not alone from the city but also country practise, and prepare to meet the constantly growing demands for facilities for specialized nursing services."

HOSPITAL INTERNES

During the last decade or two interest of hospital administrators, medical staffs, attending and interne, and of medical colleges has been focussed to a considerable degree on the question of internships. Prior to this bringing of the interne into the spotlight, there was a good deal of indifference on the parts of these various units in the career of the interne; and the interne had a sort of free and easy existence. He was not required to take histories, or do intricate laboratory work; but did do more or less indifferent physical examinations which he didn't record, made routine urinary analyses, dressed his surgical patients, wrote prescriptions for the patients of his chief and made rounds with the attending staff.

He was often chosen on account of his gentlemanly deportment.

Nowadays, it is different.

The interne is in all the large teaching hospitals putting

in a fifth or sixth year under the guidance of his chiefs. He is responsible for careful histories of patients, does routine, general physical examinations of the patient in admission and makes careful daily or bi-daily studies of the case, making proper notes of same. He does chemical examination of body fluids and assists in making examination of operating pathological specimens. He assists at operations, gives salversans and does minor operative work on the wards and in the out-patient department, if he is found efficient and trustworthy.

Unfortunately there are too few A1 hospitals in which to train all fifth year men,—this in spite of the praiseworthy efforts of the standardization committees appointed by the Rockefeller Foundation and by the American Hospital Association.

Too many of our hospitals outside of the large centres are too poorly equipped for scientific study and their staffs are too fogeyish to do much in teaching the modern graduate in medicine with his high attainments in general scholarship, biology, physics, pathological chemistry, etc., about which many of the older attending physicians know next to nothing.

Hospitals authorities should see to it that on their staffs they have men in both surgery and medicine who have had an up-to-date training, so that the young men who come to them to do interne work shall be able to pursue their scientific work, which characterized their university course. Hospital Boards should also provide the quantity and amount of apparatus and supplies necessary to the elucidation of the diseases of the patients admitted to their hospitals and for their treatment.

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Hospitals authorities should see to it that on their staffs they have men in both surgery and medicine who have had an up-to-date training, so that the young men who come to them to do interne work shall be able to pursue their scientific work, which characterized their university course. Hospital Boards should also provide the quantity and amount of apparatus and supplies necessary to the elucidation of the diseases of the patients admitted to their hospitals and for their treatment.

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(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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By John N. E. Brown, One Time Inspector of Hospitals
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During the next thousand years some of the sick were ministered to by the church, and the monastery. One of the oldest hospitals in Great Britain was a monastery—St. Bartholomews—it is a type of the great British voluntary hospitals, and of a good many hospitals in America. It was founded as a monastery in the reign of King Stephen, by his Court Jester, Prince Rahere, who renounced the Court and its round of

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Question Drawer. Discussion was free and a good deal of useful information was elicited

The business and financial aspects came in for very much consideration. Upon one matter the delegates were a unit—some measure must be adopted that will bring the income of hospitals up to the level of what is required to enable them to provide adequate service for all our citizens and population generally. After lengthy discussion as to ways and means of bringing about the much to be desired end, it was found there was not sufficient data before the convention to enable it to unite upon a definite policy. The matter was finally referred to a standing committee of five with instructions to them to request the appointment of a similar committee from the Union of B. C. Municipalities. These two committees together with the official heads of the Provincial Board of Health and the Workmen's Compensation Board were requested to get together and formulate some course of procedure which they should recommend to the Provincial Legislative Assembly so that action might be taken by that Body at its next session to relieve the hospitals of their present financial embarrassment.

The Association by resolution also made request that the Government give special assistance where necessary to enable the various Public Hospitals to prepare proper facilities to accommodate the number of tubercular patients required of them by the Hospital Act

Reports of results of Hospital Day efforts were exceedingly satisfactory. Much interest in hospitals on the part of the public had been created. It was decided to officially adopt May 12th as Annual Hospital Day. It will be recommended that efforts on that occasion be concentrated mainly upon developing public interest in the hospitals and their work, rather than to make it a direct financial appeal

At one of the public evening sessions, a most interesting and instructive lantern-illustrated address was given by Mr. J. C. Antle, Superintendent of the Columbia Coast Mission of B.C. This organization works among the logging camps and other isolated settlements along the B. C. Coast. Their plant consists of a hospital ship and three local hospitals. It is a work strikingly similar to that carried on by Dr. Grenfell on the Labrador Coast, and has been doing a noble work in a quiet way during the past eighteen years.

The following was the questionnaire taken up during the meeting:—

Section "A"—Nursing

1. Should each nurse-in-training have a room to herself?

Ans. It is most desirable that each nurse-in-training should have a room to herself. Failing this, not more than two should occupy one room, due provision being made for proper space, air, light and sitting room accommodation. The dormitory system of four, six or more, for instance, was condemned.

2. What time should be allowed a nurse-in-training for illness?

Ans. Three weeks appeared to be the period most generally adopted.

3. What length of holidays should be given the following:

(a) Official nurses on staff? (b) Graduate or head nurses in charge of wards or doing floor duty? (c) Nurses-in-training?

Ans. (a) One month. (b) One month. (c) Three weeks.

4. What should be an average salary for each of the following:—(a) Superintendent of hospital of seventy-five beds, who is a graduate nurse? (b) Graduate nurses in charge of wards or floors in any hospitals? (c) Nurses-in-training in any hospital?

Ans. (a) A minimum of \$100.00 per month with room, board and laundry. (b) \$75.00, \$80.00 and \$85.00 per month respectively for first, second and third year salaries, with room, board and laundry. (c) An allowance (not a salary) of \$8.00, \$10.00 and \$12.00 per month respectively, for first, second and third year, with room, board, and laundry.

5. Should the superintendent of nurses be the final authority in disciplinary matters, and the consequences to be meted out?

Ans. Yes, but it is deemed advisable to always consult with the Superintendent or superior officer responsible for the hospital, and if there is no such person other than herself, she may confer with the member of the Board to whom such matters are usually referred.

6. Should our hospitals only engage and allow to nurse therein such nurses as have the R. N.?

Ans. Hospitals should only engage registered nurses, but under the present British Columbia Nurses' Registration Act it is not compulsory that every graduate nurse be registered, and therefore they cannot be prevented from nursing in hospitals if they are properly qualified.

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9. What is a reasonable proportion of patients to each nurse in a general hospital, considering both day and night separately and different types of cases, such as private, semi-private and public?

Ans. One nurse to every two and a half or three patients. A distribution as follows works very well:—*Day duty*—One nurse to every five patients in public ward; one nurse to every three patients in private ward. *Night duty*—One nurse to every ten patients in public ward; one nurse to every five patients in private ward.

10. What is the best division of duty hours for nurses in order to establish an eight-hour-day system?

Ans. Four groups as follows:—*Group No. 1*—7:00 A.M. to 7:00 P.M. with four hours off. *Group No. 2*—3:00 P.M. to 11:30 P.M. *Group No. 3*—7:00 P.M. to 7:00 A.M. with four hours off. *Group No. 4*—11:00 P.M. to 7:00 A.M.

This combination seems to work out best of all and gives an overlapping service, thus minimizing disturbance to the daily ward routine.

Section "B"—Medical

1. Why should unqualified Maternity Homes be licensed by the Government and patronized by the general public?

Ans. Unqualified Maternity Homes should not be licensed by the Government or patronized by the public. The Act of Parliament respecting this matter should specify definitely such conditions as will insure competent personnel, proper and safe accommodation, with good facilities and equipment. The present regulations in British Columbia make it far too easy to start hospitals and it is hoped that more stringent regulations will be adopted.

2. Should not the public ward be abolished in hospitals?

Ans. No, but the public ward of 6, 8 and 10 beds is more desirable than the large ones of twenty or thirty beds, which today are found in many hospitals.

3. Should not each doctor be responsible for the complete medical record of the patient and this record be left in the hospital?

Ans. Yes, he should either do it himself or see that it is done by someone else.

4. How far is the Board of Directors or Trustees responsible for the kind of work done in the hospital?

Ans. Though not legally, yet the Board of Directors or Trustees of any hospital, is morally responsible to the public to see that each and every patient treated therein receives competent care so as to bring them back to health if possible in the quickest and most comfortable manner. They must make sure that all the work carried on is efficient and that good results are being obtained. They are responsible to the public for supplying good accommodation, proper facilities and equipment and above all, a competent personnel as the staff of the hospital. Usually the Board of Directors or Trustees is spending public funds, therefore they have an obligation to fulfil, to see that such funds are spent in the best possible manner.

5. What cases, other than the so-called infectious diseases, should be isolated in general hospitals?

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6. What is the minimum laboratory work that every hospital should be prepared to carry on?

Ans. Urinalysis; blood examinations, as white and red cell counts and haemoglobin; smears for Bacteria; examination of spinal fluid; examination of stomach contents; examination of feces; preservation of tissues for pathological investigation elsewhere. For further information regarding this question see Dr. Strong's paper delivered before The B. C. Hospital Association convention on July 7th, 1921.

7. Could a graduate nurse acquire sufficient knowledge and training anywhere in eight or ten months to fit her to carry on the laboratory, X-Ray and medical record work necessary for a hospital of less than one hundred beds?

Ans. Yes; the Vancouver General Hospital offers a course of ten months, apportioned as follows,—Medical Records 2 months, X-Ray 4 months, Laboratory 4 months. This

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would give sufficient knowledge to undertake the work in a hospital of one hundred beds or less. This course, we understand, is at present limited to candidates from British Columbia.

8. How can better relations and more cooperation be established between our hospitals and the medical profession?

Ans. It should not be necessary to ask a question of this kind; however, it is unfortunate that in some instances we do not find the best cooperation between the medical profession and the hospital. The following are a few suggestions:—*Firstly*—The hospital should offer the doctor an efficient service for the treatment of his patient. *Second*—The entire hospital staff should manifest a keen interest in the patient's welfare. *Thirdly*—There should be conferences at regular intervals between the doctors and the hospital authorities. The attending doctor should be consulted in hospital matters, and indeed, the appointment of advisory committees for different phases of the work will develop a more constructive interest. *Fourthly*—A thorough understanding between the hospital authorities and the doctors, with a frank cooperative spirit.

9. How can we increase the interest of the profession and the community in hospital standardization?

Ans. Keep hospital standardization before all constantly in its actual application. Use every occasion to carry it home to both the doctors and the people in the community and apply it more strictly in the hospital. The placing of literature in their hands from time to time will help to get the interest worked up. One of the best methods is to have a standardization committee consisting of professional and lay members.

10. Should a monthly medical report be sent to the Board of Directors or trustees and, if so, what should it consist of?

Ans. Yes. Monthly report to the Board of Directors or Trustees should indicate the following:—(a) Volume of work done during the month in each department. (b) Results obtained. (c) Special consideration of,—1. Unimproved; 2. Deaths; 3. Infections or untoward results. (d) Investigation made,—1. Professional care of patients; 2. Administration problems and complaints. (e) Recommendation.

Section "C"—Business

1. Should the hospitals of British Columbia adopt May 12th as National Hospital Day always?

Ans. Yes; as a day of hospital propaganda, inasmuch as

the public needs education on hospital problems and advancement.

2. Should all hospitals publish annual reports?

Ans. Yes.

3. What should be the average charges for the following:—(a) Public wards. (b) Semi-private wards. (c) Private wards. (d) Operating room. (e) Anaesthetic?

Ans. (a) \$2.00 to \$2.50 per day. (b) \$3.00 to \$3.50 per day. (c) \$4.00 to \$6.00 per day. (d) \$5.00 to \$10.00. (e) \$10.00.

4. Should the superintendent of the hospital attend the meetings of the Board of Directors or Trustees?

Ans. Yes. always.

5. Can a common basis be established for the computation of per capita in hospitals so that it may be of some comparative use?

Ans. Yes, if a proper standard of cost-accounting system be established. The basis of per capita could be as follows,—cost of all services to patient, with or without regard for such matters as depreciation, taxes, water rates, sinking fund, interest on investment or other expenditure. A common basis could be worked out in this respect. However, there must be taken into consideration the kind of service that the hospital renders to the patient, this must be more or less uniform.

6. What special economies are British Columbia hospitals effecting today which are worth while?

Ans. Several hospitals in the province are carrying out certain economies such as—gauze reclamation, linen conservation and reclamation, food conservation, and various other economies which may be touched on in a further round table conference. Further, some of the most valuable assistance to the hospitals during the past year and which has meant a great economy to them has been:—*First*—Produce Day, which is usually set for a day in September, when all the hospitals are recipients of donations from the rural communities, especially of potatoes, fruit and other produce which can be utilized to great advantage by the institution. This is an annual day amongst hospitals in British Columbia and during the past year or two has met with splendid response. *Second*—Several hospitals, especially near the fruit districts, put down all their canned fruit for the year; this is carried out usually by the women in the community or the Women's Auxiliary. *Third*—The Women's Auxiliary, as organized in various hos-

would give sufficient knowledge to undertake the work in a hospital of one hundred beds or less. This course, we understand, is at present limited to candidates from British Columbia.

8. How can better relations and more cooperation be established between our hospitals and the medical profession?

Ans. It should not be necessary to ask a question of this kind; however, it is unfortunate that in some instances we do not find the best cooperation between the medical profession and the hospital. The following are a few suggestions:—*Firstly*—The hospital should offer the doctor an efficient service for the treatment of his patient. *Second*—The entire hospital staff should manifest a keen interest in the patient's welfare. *Thirdly*—There should be conferences at regular intervals between the doctors and the hospital authorities. The attending doctor should be consulted in hospital matters, and indeed, the appointment of advisory committees for different phases of the work will develop a more constructive interest. *Fourthly*—A thorough understanding between the hospital authorities and the doctors, with a frank cooperative spirit.

9. How can we increase the interest of the profession and the community in hospital standardization?

Ans. Keep hospital standardization before all constantly in its actual application. Use every occasion to carry it home to both the doctors and the people in the community and apply it more strictly in the hospital. The placing of literature in their hands from time to time will help to get the interest worked up. One of the best methods is to have a standardization committee consisting of professional and lay members.

10. Should a monthly medical report be sent to the Board of Directors or trustees and, if so, what should it consist of?

Ans. Yes. Monthly report to the Board of Directors or Trustees should indicate the following:—(a) Volume of work done during the month in each department. (b) Results obtained. (c) Special consideration of,—1. Unimproved; 2. Deaths; 3. Infections or untoward results. (d) Investigation made,—1. Professional care of patients; 2. Administration problems and complaints. (e) Recommendation.

Section "C"—Business

1. Should the hospitals of British Columbia adopt May 12th as National Hospital Day always?

Ans. Yes; as a day of hospital propaganda, inasmuch as

the public needs education on hospital problems and advancement.

2. Should all hospitals publish annual reports?

Ans. Yes.

3. What should be the average charges for the following:—(a) Public wards. (b) Semi-private wards. (c) Private wards. (d) Operating room. (e) Anaesthetic?

Ans. (a) \$2.00 to \$2.50 per day. (b) \$3.00 to \$3.50 per day. (c) \$4.00 to \$6.00 per day. (d) \$5.00 to \$10.00. (e) \$10.00.

4. Should the superintendent of the hospital attend the meetings of the Board of Directors or Trustees?

Ans. Yes, always.

5. Can a common basis be established for the computation of per capita in hospitals so that it may be of some comparative use?

Ans. Yes, if a proper standard of cost-accounting system be established. The basis of per capita could be as follows,—cost of all services to patient, with or without regard for such matters as depreciation, taxes, water rates, sinking fund, interest on investment or other expenditure. A common basis could be worked out in this respect. However, there must be taken into consideration the kind of service that the hospital renders to the patient, this must be more or less uniform.

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pitals, have been most valuable in raising money, supplying linen, equipment and other very necessary supplies for the hospitals.

7. Should staff, other than nurses, live in or out of the hospital, and which is the most economical for the hospital?

Ans. Some hospitals find it more desirable to have all their staff, other than nurses, live out, relieving them thus of a great deal of extra equipment and trouble. However, it is generally conceded that it is more economical to keep the entire staff living in. This is impossible in many hospitals, owing to lack of accommodation.

8. What is the most desirable color scheme for walls and ceilings in a hospital?

Ans. The most desirable color scheme for walls and ceilings in a hospital appears to be a cream or buff shade or light green. In British Columbia where we have a great deal of rain, the light buff or cream walls and ceilings is the most generally used.

9. Can hospital equipment be standardized to the advantage of all our hospitals?

Ans. Yes.

10. Can the hospitals of British Columbia adopt a uniform salary schedule and also a uniform length of vacation with pay for their employees?

Ans. It might not be possible to adopt an absolutely uniform schedule, but one more or less uniform could be arranged with a degree of variation for certain conditions. Such a schedule would serve as valuable information to all our hospitals and would be a working basis for each of them.

Following are the names of officers and Executive Committee of the Association for the ensuing year:—

Officers

Honorary President.—Hon. J. D. MacLean, Victoria.

President.—Dr. H. C. Wrinch, Hazelton.

1st Vice President.—Geo. McGregor, Victoria.

2nd Vice President.—R. A. Bethune, Kamloops.

Secretary—Dr. M. T. MacEachern, Vancouver General Hospital, Vancouver.

Treasurer—Mrs. M. F. Johnson, R.N., 786 Bute Street, Vancouver.

Executive Committee.—Miss E. I. Johns, R. N., Vancouver; Rev. Father O'Boyle, Vancouver; Miss J. F. McKenzie, R.N., Victoria; E. S. Withers, New Westminster; Miss M. P. MacMillan, R.N., Kamloops; Miss L. S. Gray, R.N., Chilliwack; Charles Graham, Cumberland; D. G. Stewart, Prince Rupert; W. E. Wilks, M.D., Nanaimo; G. R. Binger, Kelowna.

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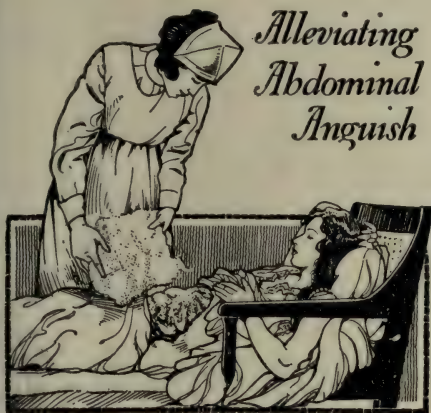
By referring to page (?) of this issue, our readers will see a most interesting announcement in reference to a chemically pure natural Epsom salts, now being mined in Canada. This preparation is known as Basque Natural Epsom Salts and is being mined from natural deposits at Basque, B.C. Basque Salts will respond to all tests for purity usually applied for medicinal Epsom salts. It is easy to take, lacks the usual bitter taste and will be found a most beneficial remedy in all cases where rapid elimination is desired. This preparation is being placed on the market by the Basque Products Co., Toronto.

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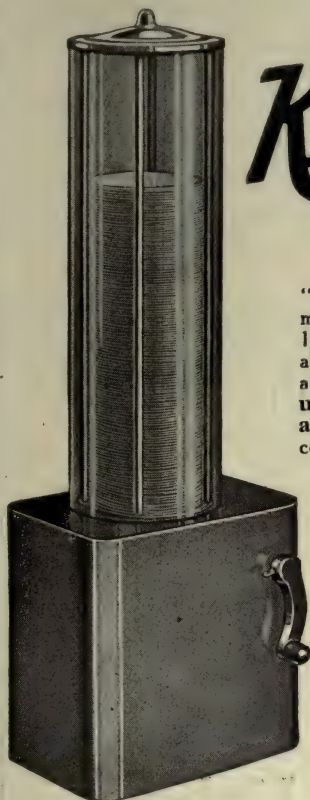
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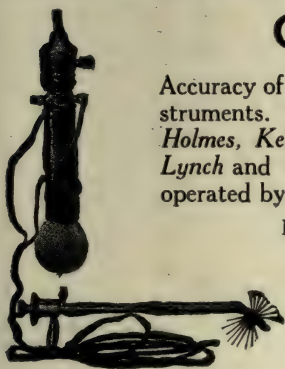
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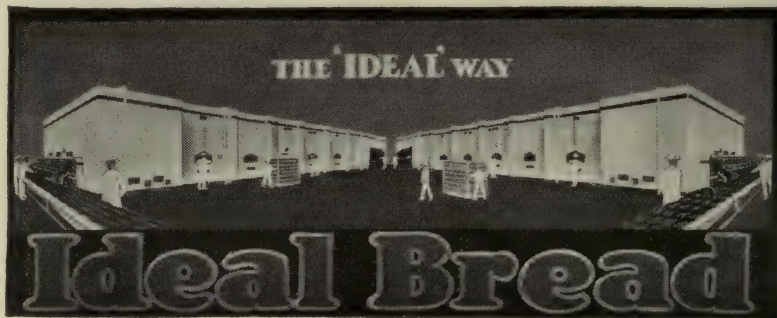
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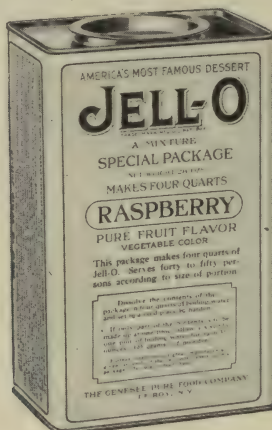
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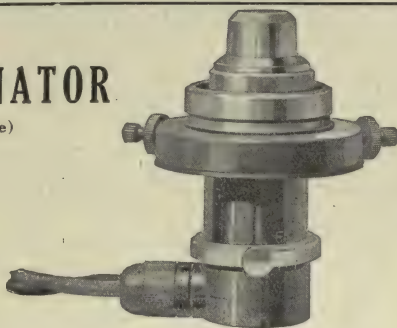
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Vol. XX

Toronto, November, 1921

No. 5

CONTENTS

EDITORIALS

	Page
The Payment of Hospital Staff	127
As You Were	128
Skill Plus	130
Radiology	130

ORIGINAL ARTICLES

Hospital Construction and Up-keep of Hospitals, R. Langton Cole, F.R.I.B.A.	133
The Betterment of Hospital Conditions, Herman E. Pearse, M. D.	140
Hospital Diets, Walter Baumgarten, M. D.	149
The Manitoba Hospital Association	154

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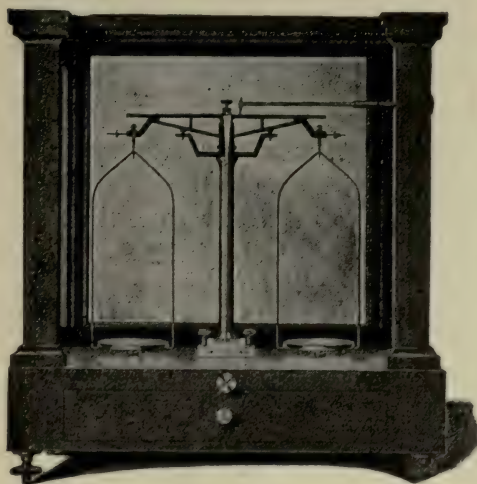
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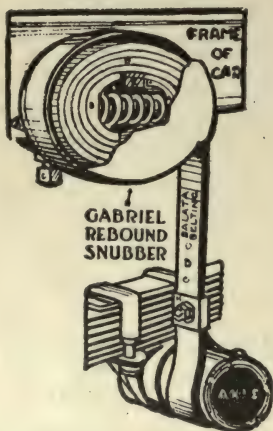
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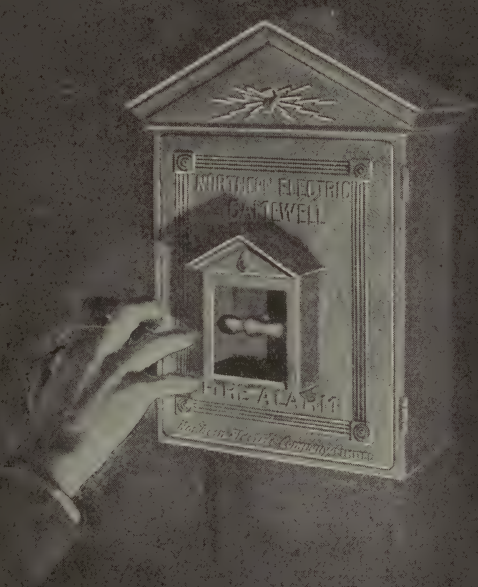
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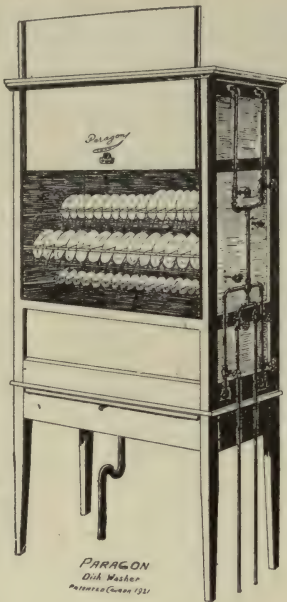
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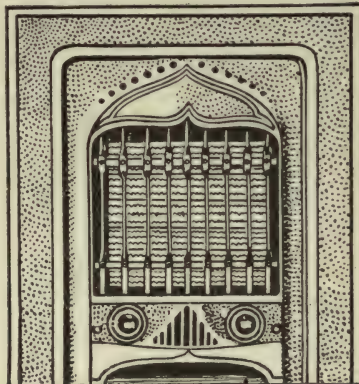
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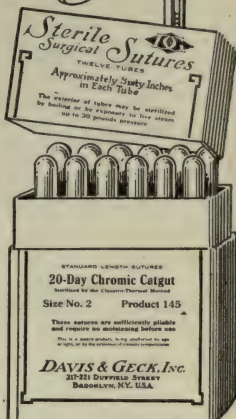


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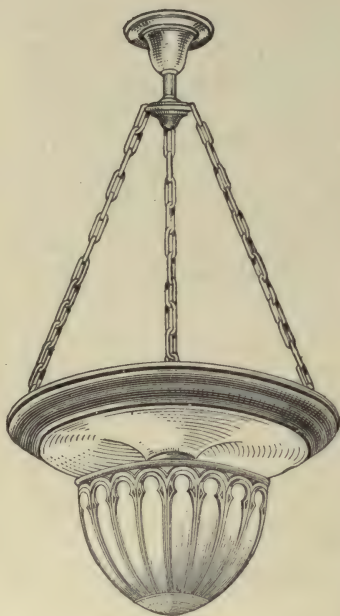
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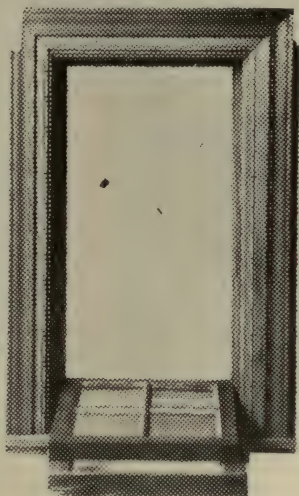
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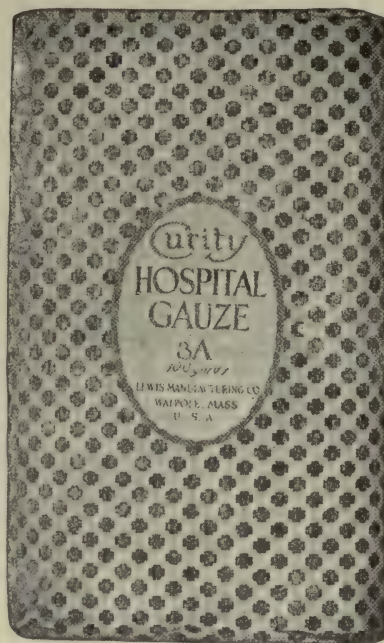
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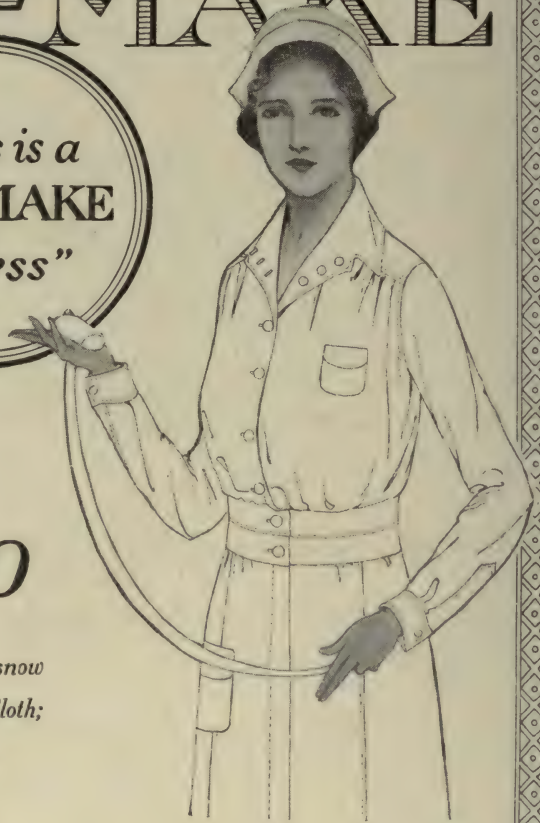
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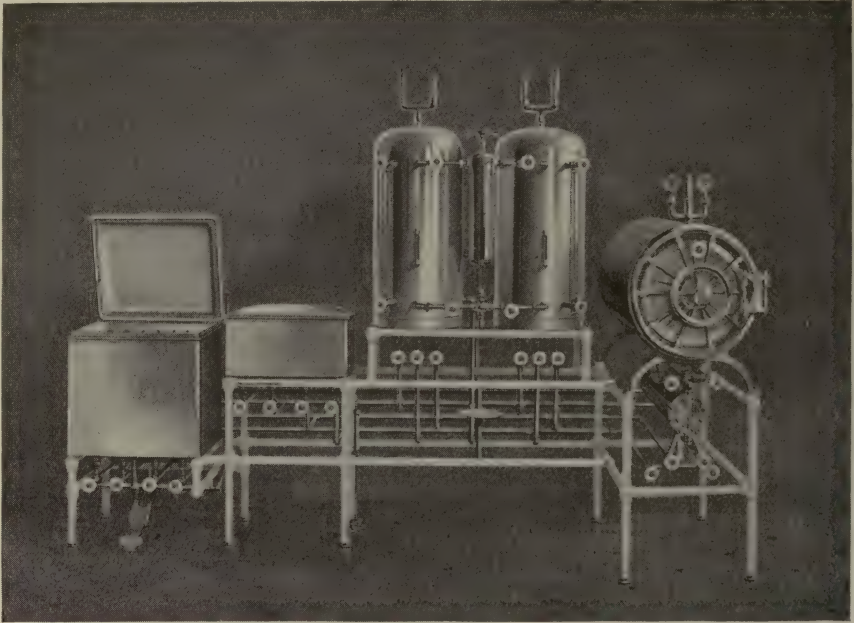
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The Hospital World

TORONTO, CANADA

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and Public Charitable Institutions throughout the British Empire

Nov., 1921

THE HOSPITAL WORLD

No. 5

PAYMENT OF MEDICAL STAFF

In a few hospitals members of the medical staff are paid for their services. This custom should become general. In times past medical men have fallen over one another in order to get a position on the staff of certain hospitals. Many of them, after years of faithful, gratuitous service have been unceremoniously kicked off, supplanted or honored (?) by a place on the consulting staff. Shrewd business men on the Boards of Trustees have played on the innocence and vanity of the doctors and gotten a lot of work out of them for nothing—except prestige. All doctors in hospitals for insane are on full time and on salary. If this system works well for the people with diseases of the brain, why shouldn't it for folks with cirrhotic livers or Bright's disease? The physicians in sanitariums for tuberculosis are on salary. Why shouldn't physicians attending poor patients in general hospitals?

The plain truth is that the profession has been going it blind in the matter of hospital work. In the Army all the medical officers were paid for their work. Why aren't civilian doctors paid for their work done in hospital public wards? The plumbers, electricians, grocers and butchers make them pay up, but these same gentry who fall ill and who patronize hospital

public wards have to be looked after gratis by the doctors! The thing is absurd. The laborer is worthy of his hire. These rich hospital corporations should pay their staffs; and no man should serve on the staff without a fair remuneration. Doctors are slowly waking up; the lawyers have been awake for some time.

We are pleased to note that the principle of the payment of members of the medical staff is being adopted more and more as time goes on.

Many general hospitals are paying their internes. This is as it should be. All internes everywhere should be paid; and the attending physicians and surgeons as well.

AS YOU WERE

Many doctors are back from the woods and the lakes and the Continent of Europe, into harness again—down to business once more.

There are those of the craft who love their work, are forgetful of self and respond to all calls of practise and of their own family. Some give of their time and energy to their church or their municipal council or other public or philanthropic work. These need two words of advice:—(1) Don't attempt too much; (2) Be systematic. We strongly urge on our brethren who have large practises to stick to their professional work, attend to family obligations and get some daily physical diversion (play of some sort). They also need some time for reading, professional and miscellaneous. Even with these several activities much can be done by adopting a system—make a program. The meals must be taken at a regular hour and unmolested by

telephone or door calls, if possible. Eight hours' sleep must be secured some time in the twenty-four. Carry the visiting list, making entries immediately after each visit or call. Try to keep a note of each cash receipt and payment at the time. Take five minutes at 7 p.m., to transfer these items to the ledger and cash book. Take the succeeding few minutes to briefly enter on cards in a book the few cardinal points about each case seen. Some men do this at the time of examination. Answer all letters promptly. Keep copies of all prescriptions. Stick carefully to office during office hours. Keep the office posted of your whereabouts and how you can be gotten. Call up your office frequently when on rounds. Try to get an hour to read up such cases as are of interest and upon which you feel need of being posted. Examine your patients as thoroughly as you can and do something **to relieve any suffering or discomfort they complain of** even though you haven't completed your diagnosis.

Take your play or exercise every day—cheerfully if you can. Have Osler's essays on "The Master Work Equanimatis," and a "Way of Life;" Weir Mitchell's "Dr. North and His Friends," "O Henry," "James Moffatt's Translation of the New Testament," and "Don Quixote" on a little shelf at your bed head near a shaded light to browse among after you have undressed, said your prayers and put on your night cap. That is, if you are not too tired. Have a light-proof screen between yours and your wife's twin bed. She may like to read one of your favorite stories, poems or essays to you; and thus put you to sleep.

You will gain some good hints from a magazine called "System."

Plan for your two or three weeks' post graduate study and don't fail to attend your medical society meetings.

To no one is the old advice more applicable than to the busy physician;—to have—

*A place for everything;
Everything in its place;
Mind your own business.*

SKILL PLUS

There are two main factors which make for success in hospital work—skill and kindness. Both are important. Doctors and nurses ought to know their work and be artists in the performance of it. They should love it for its own sake, apart from any monetary gain. Besides this, they should always remember they are dealing with folks who are not only sick or wounded in body but generally much distraught in spirit; and while they minister to the stricken body they should not fail to minister to the stricken mind. The patient is often fearful, melancholy, irritable, irrational, easily perturbed—very sensitive to pain or slight. Doctors, nurses and students who are tactful and able to handle with grace patients emotionally unstable, wilful or unreasonable, and at the same time render skilful attention to the sick body, have entered the Promised Land of their profession.

Such are to be congratulated; and the hospital which has the greatest number of these “top-notch” people around is the hospital to which the people will flock for help when they are sick.

RADIOLOGY

The discovery of the Roentgen Ray has revolutionized the study of surgery and that of certain departments of internal medicine. The discovery of

radium and its qualities and properties have revolutionized our fundamental conceptions in physics and chemistry.

Since their introduction into the domain of therapeutics hospitals are slowly creating departments and securing men trained in radiology to manage them. Incidentally, men will come to these departments in the larger institutions for training.

The Mayo Foundation has converted their therapeutic department into a teaching department and has accepted a number of fellows for training. They are required to do 150 post-mortem examinations, besides the regular work in radio-diagnosis and radiotherapy. Studies will be made in the pathological museum and in the history room of reports of clinical examinations and also in the big reference library. Patients for operation will be followed into operating room and the X-ray diagnosis checked up with the operative findings.

After a three year course the student must write a thesis to shew his grasp of the subject before being granted the degree of Master of Roentgenology.

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HOSPITAL CONSTRUCTION AND UP-KEEP OF HOSPITALS.

MR. R. LANGTON COLE, F.R.I.B.A.

Mr. R. Langton Cole, F.R.I.B.A., gave the first lecture on this subject at the National Hospital for the Paralysed and Epileptic on February 15th, 1921. He mentioned that a Hospital should be well planned, well built, well drained, well lighted, heated and ventilated, and should have a good water supply, and proceeded to deal with the two first items, plan and building. Showing a block plan of King's College Hospital (Mr. W. A. Pite, 1915), a ward plan of the National Hospital for the Paralysed and Epileptic, and a plan of a single ward unit at Dartford, he pointed out the following main elementary features common to all modern hospitals.

(1) The site should be sheltered from the north, and should slope gently to the south, south-east or south-west. (This might, of course, be difficult in town neighbourhoods.) The north point should be marked on all hospital plans.

(2) The wards should be about 26 feet wide, with windows both sides, should accommodate from twenty to thirty patients each, and their length should run north and south, so that the windows on either side would admit the sun the whole day. If possible, there should be a large window at the south end, with a balcony outside it, so that patients able to leave the ward could be placed there, in or out of bed, to obtain the maximum of sun and air.

The height of a ward would be about 12 feet, the beds about 6 feet centre to centre, with a window between each (infirmaries two beds per window), and the cubic space would thus be about 13 x 6 x 12, say, 1,000 cubic feet per patient. This space may be increased to 1,500 feet or reduced by necessity (as in war hospitals) to 500 feet.

(3) The sanitary annexes would usually be at the south end on each side of the balcony, one containing the bath-room and wash-basins, the other the W.C.'s and slop sink. Both would be approached from the ward by cross ventilated lobbies. In many cases, however, these annexes were placed in the centre of the ward's length or at its inner end. There should be a wash basin inside each ward, usually near the centre of the length; at King's College they have a bay provided for them. Each ward would also have its day-room for patients able to leave their beds, a ward kitchen, isolation room for special cases, and frequently a sisters' room or duty room. These, together with the ward, constitute the ward unit, the most important part of the hospital—for which it in fact exists.

In a large hospital these ward units would be numerous and would be attached at the north end to a main corridor running east and west, connecting them to the remainder of the hospital.

(4) Hospitals should be constructed of fire-resisting materials, not excepting the roofs, as serious fires had occurred from using timber roofs. Ward floors would preferably be of composition of the Durato class (many King's floors are linoleum on cement), the walls and ceiling of hard plaster finished with enamel paint, the windows, sashes and fanlights, or of one of the patent forms available. (The lecturer expressed a preference for sashes and frames, with fanlights over, the sashes fitted with a pivoting arrangement for cleaning.) The doors would be of the Gilmour type, plain all over, with glazing if wanted. All corners and junctions of walls, floors and ceilings would be rounded to facilitate cleaning.

The lecturer mentioned that wards were often built on arches so as to provide ventilation below as well as at the sides (as at King's College). He did not recommend this plan, as this space must be regularly cleaned, and he considered it much better to place the floor on the ground, or to have a real basement below it utilized for purposes connected with the building.

(5) The administration block is usually placed in the centre of the building, and often (as at King's) on the opposite side of the main corridor to the wards. It would contain the secretary's offices, board room, porters' room, matron's and other offices, doctors' rooms, electrical and other rooms for special treatment, pathological laboratory, medical school, etc., etc., kitchens and stores, with lifts to all floors.

(6) The out-patients' department, often of very great importance, is usually placed on one side of the administration block, with convenient and separate entrance and exit for patients.

The plan is generally that of a central waiting hall, with consulting rooms, surgery, examination and recovery rooms grouped round it. On one side is the dispensary, arranged to facilitate, as far as possible, the issue of drugs. A small canteen is desirable, as patients have often to wait for many hours. The circulation of patients should be provided for.

(7) An isolation block, if provided, will be a small hospital in itself, detached from the remaining buildings and containing two or more small wards, with their ward kitchens, day-rooms and sanitary appliances complete.

At Queen Mary's Hospital, Wallington (Infectious) all the blocks are separate, and the service is performed by motor lorries.

(8) The staff of a modern hospital is approximately one for each patient, but these will not all sleep in the building. The nurses are at present one for every two patients (King's, 600 beds, 400 nurses) and are accommodated in a nurses' home, usually a separate building, as at Guy's and St. Thomas', or part of the administration block, as at King's, where they occupy the upper floors. Nurses' rooms are usually about 11 feet x 9 feet (100 square feet) with a common dining room and recreation room. Sisters' rooms about 15 feet x 12 feet. The building should be arranged so that every room gets the sun once a day. "Where the sun never comes, the doctor

does," as the Italians say. The new nurses' home at St. Bartholomew's will have special wards for nurses, with beds for one-tenth, and all the usual adjuncts.

(9) Servants usually sleep in the administration block or over the wards. In time, no doubt, a separate home will be required for them also. They should have dining and recreation rooms.

(10) The operation block is usually a separate unit attached to the main corridor. At King's there are two blocks, each of two stories, each story containing an operation room about 20 feet square, with large recess for sinks, a surgeons' room with bath, a dressers' room, anæsthetic room, recovery room, and ante-room, the latter used as an entrance for students, for whom there is a gallery in the operation room.

Every part of this block is, of course, treated with the utmost care to facilitate good ventilation and perfect cleanliness. Floors are usually of Terrazzo or Durato, and the walls of plaster with enamel paint. Tiles are not in favour, owing to the numerous joints. It is difficult to avoid cracks in the floors, and they have occurred in walls when warmed by buried steam pipes.

II.—Repairs, Cleaning and Disinfection.

Mr. R. Langton Cole's second lecture was given at the National Hospital for the Paralysed and Epileptic on February 22nd, 1921. Dealing first with repairs, he pointed out the importance of trifles, and said that the man or woman who noticed a broken hinge or missing fastening and had it attended to at once was in a fair way to become a good superintendent for a large hospital. Organisation for reporting repairs should be insisted on. Every member of the staff should be instructed to observe and report at once to the secretary (either directly or through those over her) any want of repair which she might come across in her daily work. The secretary (or superintendent) would order the repairs and would thus keep in touch with the general condition of the hospital. A building commences to decay directly it is finished, and it is only by constant watchfulness that decay is prevented

from becoming serious. Ordinary repairs best attended to by the hospital staff, i.e., by an engineer, who should be a competent fitter, and able to attend to simple plumbing and electric lighting, a carpenter and the stokers, who should be able to act as "mates" in almost any work. It should not, for instance, be necessary to send for a builder to put in a new washer, renew a sash line or re-wire a pendant. The hospital should possess (mostly under the engineer) a small stock of materials necessary for repairs, and sufficient tools to enable them to be carried out.

With regard to painting, it is usual for one or more ward units to be cleaned or repainted every year. Paint on walls and ceilings is better than distemper, as it can be frequently cleaned, and in many cases this work could be done by members of the staff. H.M. Office of Works had abandoned the use of lead paint in all Government buildings and this example should be followed. There are plenty of good paints free from lead available for all purposes.

The lecturer touched briefly on the principles of modern sanitation, recommending iron drains, lead trapped closets with porcelain lining, baths, lavatories and sinks with "Ajax" wastes, although the latter are now difficult to obtain.

Testing of drainage, etc., should be done regularly by an expert, but supervision should be attended to daily by the staff. Every appliance must be kept scrupulously clean, inside and out. Look behind and below everything daily, and see that all hidden places are as clean as those that are easily visible. Servants' and porters' lavatories are as important as those of the wards, but are often overlooked. The reporting of defects in sanitary appliances is specially needful. A set of drain rods and a plunger for clearing wastes are useful tools.

Air flues, vertical or horizontal, should be regularly cleaned and frequently inspected. They should not be used as resting places for books or flowers.

The outside of the premises should have the same care as the inside. Areas, courts, etc., and the gullies, etc.,

therein should all be constantly examined and cleaned. There are no appliances known which will keep themselves clean without some handwork.

Cisterns should be examined and cleaned at least once a year. Draw-offs will usually be on the main, and baths and closets only on the cistern, as a reserve, but even so, it is not satisfactory to use water contaminated by dead birds or mice.

Speaking generally, constant vigilance and intelligence are the chief requisites for dealing with repairs.

As regards heating, it is usually by steam with iron radiators made to swing out from the walls so that they can be cleaned; and this cleaning should be carefully attended to. Attention was called to the value of exhaust steam in cases where the hospital uses steam for generating light or power. It is much better to use steam and utilize the exhaust than to use oil or gas engines which have no by-product of this description. Oil fuel can be used if it is desired to avoid the troubles of coal but at present prices it is not economical.

Open fireplaces are usual in wards, recreation rooms, etc., supplemented by steam radiators. In wards the flues pass under the floor and then up the outer walls.

Cooking is usually by steam and gas, but electric cooking is making rapid strides and has many advantages over gas. There are several restaurants now running on steam and electricity and the subject should be watched by hospital authorities.

Hot water is generally supplied from calorifiers, which are iron vessels heated by the steam from the boilers. Hot water is sometimes used for heating with small pipes, the water circulated by steam or electric pumps.

As regards disinfection, the local authority will usually disinfect any infected room and its bedding and other contents. Disinfection by the hospital would usually consist in removing the contents to a chamber where they would be treated with formalin.

It is not necessary to disinfect a whole ward for one infectious case.

The lecturer invited questions, and some useful points were dealt with. He would be glad to reply to any further queries addressed to him at 23 Throgmorton Street, E.C.
—The Hospital Gazette.

A WARNING

The thrilling rescue from death of Joseph Diazner, four years old, of Brooklyn, was revealed and the placing of additional iron bars before the windows of the wards in the Brooklyn Eye and Ear Hospital was considered.

The new bars are to prevent the possibility of a recurrence of what might have caused the child's death.

Following an operation for the removal of his tonsils and adenoids, little Joe was tucked in a cot on the third floor of the hospital, beside seven other little patients. The nurse, who left the room for three minutes, noticed on her return that but seven of her patients were in their beds.

Joseph had climbed to one of the windows on the Schermerhorn side of the building, squeezed through the bars and was hanging outside, in imminent danger of dropping to his death.

The flutter of the child's nightie attracted the attention of passersby, and while some hastened to notify Superintendent R. A. Baker of the child's peril, two young men raced to a point beneath the swaying figure, stripped off their overcoats, knotted them together by the sleeves and stretched them out as a makeshift safety net.

A moment later Joseph's grasp on the window-ledge relaxed and he went hurtling down. But the safety net proved effective and he dropped into it uninjured.

THE BETTERMENT OF HOSPITAL CONDITIONS*

Herman E. Pearse, M.D., Kansas City, Mo.

*The Address in the Public Meeting at the 64th Annual Meeting of the Missouri State Medical Association, St. Joseph, May 24-26th., 1921.

The changes that are coming about in the attitude of the world towards standards of living having so affected the question of hospitals that hospitals are fast becoming of paramount importance everywhere. The day of isolated effort is giving way to the united efforts of groups. Groups of physicians need laboratories and technicians. These find their best setting in hospital life.

Hospitals were built as a necessity in early days and were largely confined to charitable work of churches. About twenty-five years ago surgical work took on an added impetus. The fifteen years preceding has seen the discovery of antiseptic surgery and the invasion of all the great cavities of the body with more or less success, and the surgery of disease came into its own. It called loudly for a place and a setting in which surgical operations could be done under the most favorable circumstances.

From 1890 to 1900 new hospitals began to spring up, and from 1900 to 1920 has seen the development of the great, private pay hospital consisting of fifty to five hundred beds, and carrying an overhead expense of hundreds of dollars a day. Coincident with this the trained nurses' profession developed very rapidly, and passed in its progress from a wage of ten dollars a week to one of thirty-five and forty dollars a week, and from the nurse as a menial to the nurse as a professional woman. It was from the growth of the great private hospitals with their wards of pay patients and highly trained and highly developed special nurses, that the charity hospitals have been compelled to take their cue.

With the rapid development of hospitals came the trend of the profession to the cities and to the hospitals in which to do their work. It is so much easier to obtain results surrounded by all the facilities of a modern hospital that physicians became impatient with the handicap of isolation. Hospitals grew. Laboratories multiplied. Specialists advanced in skill. Surgery grew rapidly in scope and importance. The surgery of disease, particularly abdominal

and pelvic disease was established and the surgeon was sought for in many cases where the physician had formerly been in demand. Ambitious men, commercially ambitious men, were not slow to see the better economic position of the surgeon, receiving large fees from patients gathered in a hospital as compared with the physician driving about to his patients in isolated communities.

New hospitals were opened. Ambitious surgeons promoted organizations to build and own hospitals. Many of these hospitals depended largely for their support, in fact most of them did, on the payment of patient's fees, and the fees were made high enough that they not only paid the expenses but paid quite handsome profits to their owners. Consequently such hospitals were as open as a metropolitan hotel. Any surgeon whose patient had the price for rooms could have the room. Whatever the doctor chose to do in the way of treatment or operation he was allowed to plan and execute. No record was required, no check was placed upon the individual work; in fact, it was considered a decided insult to in any way inquire what the doctor was doing in the hospital as long as the patient took a private room and paid for it.

It became apparent about ten years ago that in some instances hospitals were being abused, or rather that patients were being abused in some hospitals and that occasionally hospitals were being made the means of such abuse, unnecessary operations were being done; the patients were exploited; exorbitant fees were charged for things that did not require great skill. Physicians were paid fees to bring patients to the hospital; fee splitting with surgeons took place and rebates were allowed. The matter came before the profession at its great annual gatherings and received discussion. As usual the healthy sentiment in the medical profession undertook the cure of its own ills rather than wait for outside interference, and in 1913 the American College of Surgeons began its propaganda for reform.

The best men of America were called into conference, and after a year of discussion certain conclusions were reached, based on the rights of patients who were sick in hospitals, upon the rights of communities who supported hospitals and upon the rights of physicians and surgeons.

who worked in them. Certain conclusions have been reached as to standards and procedure. It is agreed that every hospital should have a definite minimum standard of excellence. Until this is reached the efforts of its staff must be untiring toward attaining this end. The minimum standard must include:

(1) A decent building and grounds where it will be possible for the sick to be treated and nursed.

(2) A nursing staff of capable trained nurses.

(3) An equipment to include (a) chemical laboratory, (b) pathological laboratory, (c) roentgen-ray laboratory, and (d) record room.

(4) An organized staff of physicians and surgeons.

(5) The above must be governed by a hospital board whose aim is not commercial; who seek the cure of patients; who endeavor to give value received for every dollar the patient pays, and of every dollar of money given to support free beds. Finally given the building and equipment, and the nurses, and the records and filing system, staff and the governing board, there must grow up a hospital conscience, and a hospital honor, and a hospital character as clean and as honest and as upward-looking and as forward-looking as the responsibilities and duties of a doctor to his patients demand.

The American College of Surgeons now found it advisable to enlarge somewhat upon the essentials enumerated above and to that end has set out its minimum standard of what a hospital should be to give fair service to its patients. This is as follows:

The American College of Surgeons' Minimum Standard

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," or need it affect the various existing types of staff organization. The word staff is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," the "visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (a) competent in their respective fields and (b) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations and policies specifically provide:

(a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.)

(b) That the the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical record of patients, free and pay, to be the basis for such review and analysis.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes the personal history; the physical examination, with clinical, pathological, and X-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available.

5 That clinical laboratory facilities be available for the study, diagnoses, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic, and fluoroscopic service in charge of trained technicians.

The American Medical Association Standard

The American Medical Association joined in at once, adopting the idea of a minimum standard below which a hospital was hardly doing justice to its patients. They, too, defined more clearly what the equipment should be and history writing should be and what the staff should do.

Their standard is as follows, basing the needs of a hospital for the training of internes:

Tentative Schedule of Essentials in a Hospital for the Satisfactory Training of Interns

Prepared by the Council on Medical Education of the
American Medical Association

I. The Staff of the Hospital.

1. There must be an organized staff.
2. Staff physicians should be men of unquestionable integrity both professionally and morally.
3. They should be proficient in the special fields in which they work in the hospital.
4. They should give personal attention to the patient under their charge, some member of each department visiting the hospital every day, and every member of the staff should visit the hospital at least once each week.
5. They should assume an obligation to direct and supervise the training of the internes admitted to the staff.
6. (a) A clinical conference of the attending staff and the internes should be organized and held at frequent intervals at least monthly, at which new cases and the problems they present should be discussed. (b) There should also be clinical and pathological conferences, for the attending staff and internes where the antemortem clinical picture is presented and compared with the necropsy findings. (c) There are also hospital medical societies at which staff members and internes are encouraged to present cases which have been worked up from the clinical point of view and on which they have read up the available literature.

II. The Equipment of the Hospital.

1. A pathologic department equipped with facilities for necropsies, this work to be in charge of an expert, who may be a member of the staff skilled in such work.
2. One or more small clinical laboratories for work by the interne or in direct connection with the wards for the routine examination of blood, urine, stools and gastric con-

tents. Within the hospital there should be also a clinical laboratory in charge of an expert who shall be responsible for the more technical, chemical, bacteriologic and serologic work and examinations.

3. A roentgen-ray department in charge of an expert roentgenologist and equipped to do roentgenographic, fluoroscopic and therapeutic work.

4. A working medical library containing a fair supply of modern standard text and reference books, the better medical journals, and suitable charts and models. Bound volumes of the better medical journals for recent years constitute a very satisfactory part of a hospital medical library.

5. Adequate provision for the housing and recreation of internes.

III. Histories and Records.

1. Complete histories should be taken, giving the patient's complaint, physical examination at time of admission to hospital, laboratory findings, description of operation, if any, daily record of case, condition and date when discharged from the hospital, end-results, and, in case of death, necropsy findings if necrosy is performed.

2. The histories should show, by signatures or initials, the persons writing them or parts of them. This will show not only the work of the interne, but also the supervision over it by members of the attending staff. In hospitals where senior medical students act as clinical clerks, it should be the duty of the internes to supervise and correct the histories written by the students and the records they keep.

3. The records should be carefully kept and placed in charge of a trained historian. This will not only guarantee better records and better care from the patient's point of view, but also will actually protect the hospital itself, especially in certain medical legal cases.

4. The records should include an alphabetical index of the patients, another arranged by diagnoses, and, for surgical cases one arranged from the standpoint of the regional part involved. For the alphabetical index cards might be used

which would show the end-results, sometimes referred to as the "summary" of the case.

The Catholic Hospital Association Standard

The Catholic Hospital Association have endorsed the plan for a hospital improvement. On June 20, 1918, at their meeting in Chicago the following resolutions were passed:

Be it Resolved: That we, the Catholic Hospital Association of the United States and Canada, now assembled at Chicago in our third annual convention, approve of the work being done by the American College of Surgeons for the standardization of hospitals, and assure the College of our fullest co-operation in its endeavor for the betterment of hospitals and the resultant increased welfare of mankind.

Be it Resolved: That we, the members of the Catholic Hospital Association, pledge ourselves to organize controlled staffs in our hospitals; to establish or continue an adequate system of case records, with a Sister in charge having full authority to demand the careful co-operation of doctors, internes, and nurses; to secure from our superiors, staffs, or friends, funds properly to equip all necessary laboratories and to bring about as soon as possible the scientific training of our Sisters and technicians of all kinds, anesthetists, dieticians, record keepers, and social service experts.

We further pledge ourselves to urge all surgeons who are privileged to practice in the hospitals of the Association, and who are not at this time Fellows in the American College of Surgeons, to qualify as soon as they are able for Fellowship in the College.

We further wish to express our desire that all doctors who practice in our hospitals be or become, as soon as practicable, members in good standing of their respective county medical societies and contribute their share to the active medical life of said societies.

We further wish to express our conviction that the secret division of fees, as condemned by the American College of Surgeons, is an unethical and nefarious practice which we pledge ourselves to keep out or root out of our hospitals.

On June 21, 1918, at a meeting in Chicago of Bishops and Archbishops (or their representatives) of the Catholic Church in the United States and Canada to consider the program of the College in relation to Catholic hospitals, the program of the College was approved.

The Army Medical School, the Navy Medical School, the American Trained Nurses' Association, the Association of American Medical Colleges, the American Hospital Association and many others have endorsed the plan.

Dr. M. T. McEachern, Superintendent of Vancouver General Hospital, says after years of experience in practically administering the standard in a hospital: "The minimum standard is not, perhaps, so simple as it looks. But certainly it does not impose too great a burden of effort upon the doctor or upon the hospital. It calls for no undue expenditure of money. It is not impertinent, for it is based upon the sound principles of practice which the profession long ago accepted. It forces a constructive and co-operative scrutiny over all medical work in the hospital; unnecessary surgery, incompetent surgery, lax and lazy medical service, and all commercialism in medicine go down before it.

"The minimum standard is not a theory. Wherever it is tried with sincerity, it succeeds. One result of it, too, is that it swiftly submerges personal prejudices among doctors and unites them under those bonds which have always made the profession great.

"Again, *World's Work* last spring assigned to an investigator the task of making a report upon the effect of the minimum standard among hospitals. This report was published in the magazine for June, 1920. With regard to the minimum standard the writer, Mr. Hawthorne Daniel, says in part:

"The statement is simplicity itself, and yet, with all of its simplicity it contains just the suggestions that lead to the conservation of lives and the elimination of unnecessary operations; just the suggestions that bring about the conscientious care that every patient in every hospital has a right to expect.

" 'From coast to coast the idea is changing the conditions in hospitals. Everywhere there is the ferment of development, the activity of improvement. . . . The world of the hospital is changing. An advance normally to be expected in twenty years has come in three. For this opinion I am indebted to President Henry S. Pritchett of the Carnegie Foundation.' "

As chairman for several years of the Committee on Hospitals of this Association, I must again call attention to the need of staff study of hospital conditions and staff effort to remedy them. Commercialism with its fee splitting and its unnecessary operations must be searched for and eliminated, and in each community the men of our profession must do this themselves. The standardization committee is not a police committee. They do not enforce a standard. The profession of America and its people do that. The committee will help any hospital improve; will assist them in organizing; will help install its record system; will help in any way, but the responsible management of each institution must carry on the work and each staff must direct, advise and assist the managers in their task.

It is impossible to get away in the conduct and up-building of a hospital without competent record keeping. Good record keeping does not require any blanks. It does not require any expense. It only requires careful attention to the details on the part of the doctor. A plain piece of paper headed "Personal History" is as good as anyone's blank. Another piece of paper headed "Physical Examination" is as good as any blank. If the real history taking is done, and if the real physical examination is done and a record of it written the day of the patient's entrance into the hospital, the character of the service improves from every angle point. Good record clerks must be hunted for, and usually it is necessary upon introducing a record system to obtain a competent record clerk from a hospital already having one, and allow two or three months for the training in of a competent clerk who wishes to learn to keep records.

It is up to the State Medical Association of Missouri to make all of its hospitals high-grade hospitals, and to bring credit to the medical men of the state, and to the hospital

people of the state. If we do this, money in abundance will be furnished by every community to establish hospitals wherever they can be needed. If we keep commercial methods in our hospitals and exploit patients in them, money will not be forthcoming for the building of new hospitals, and for the better equipment for those already builded.

The keynote of the whole situation is record writing, record filing, and record study. It is case history writing, case history filing, and case history study. It is careful physical examination writing and careful physical examination study that will build up the doctor, build up the hospital, and improve the condition of the patient. Let us work together for this end, remembering that the keynote of a successful hospital is well-ordered, active, well-patronized record room.—Journal of Mo. Med. Ass.

1305 Rialto Building.

HOSPITAL DIETS

WALTER BAUMGARTEN, M.D., WALTER FISCHER, M.D., and
HORACE W. SOPER, M.D., St. Louis.

In order to systematize the management and the ordering of diets in the hospital, the Medical Staff of St. Luke's Hospital, represented by the members who are publishing this report, as a committee, with the valued assistance of Miss Fagan, dietitian to the hospital, have arranged the list of diets which form the body of the present article. The diets which have been evolved for various diseases as the result of recent metabolic and biochemical studies have become so definite, and require such exact preparation that it has been deemed desirable for administrative purposes, to gather them together in an easily available form. The diets selected are those which it is thought will simplify and facilitate hospital administration.

The first four diet lists are general in character. They are intended for patients in various stages of illness and convalescence from diseases which require no adjustment of diet other than may be demanded by the general conditions of their illness. In the fifth list (diabetic diet) no

specific articles or quantities can be designated, as its most important feature consists in that it should be adapted to each individual case. The principles of its application may be found in Joslin's Monograph on diabetes melitus, to which the reader is referred. In the hospital it is desired that the diet for each individual case be determined on the basis of the quantity of carbohydrate, protein and fat content desired, leaving it to the dietitian to work out the actual articles of each meal.

The nephritic and hypertension diets permit of more definite specification, so that lists containing low, medium and high protein quantities and caloric values have been set down. It is, however, to be understood that when greater individualization is desirable, it should be carried out on recognized principles.

Finally, the writers would point out, that effective use of many of the diets will be greatly enhanced by the aid obtainable from a well-functioning clinical laboratory and laboratory for blood chemistry.

Diet Lists.

1. Liquid Diet.
2. Soft Diet.
3. Light Diet A.
4. Light Diet B.
5. Regular Diet.
6. Diabetic Diet (Allen)—Individual Diets specified.
7. Low Proteid Diet: General.
8. Low: (25 g.) Protein Nephritic Diet.
9. Medium: (35 g.) Protein Nephritic Diet.
10. High: (50 g.) Protein Nephritic Diet.
11. Mosenthal (Renal Functional Test.)
12. Typhoid Diet.
13. Coleman's Milk Diet.
14. Ulcer Diet.
15. Lenhartz Ulcer Diet. Post-operation Diets for:
16. Stomach Cases.
17. Colon and Rectal Cases.
18. General cases.
19. Cardiac Decompensation Diet.
20. Karrell Diet.
21. Anti-Constipation Diet.
22. Purin-free Diet.

Every physician is requested to designate by number the Diet he wishes to specify for his patient. Complete lists may be seen by applying to the nurse in charge of the Division.

1. LIQUID DIET.—Feedings every two hours, 6 oz. each.

Meat broths.
Meat juices.
Strained soups.
Fruit juices with water.
Albumenized drinks.
Cereal gruels.
Tea.
Coffee.
Cocoa (if permitted).
Milk (if permitted).
Bulgarian milk.

2. SOFT DIET.—Feedings every three hours.

Any liquid food.
Cream soups.
Milk—whole and Bulgarian.
Custards.
Junkets.
Ice cream and ices.
Gelatin.
Cereals.
Eggs—soft cooked.
Milk toast—butter.
Blanc mange.
Stewed fruits—well cooked and strained.
Cottage cheese.
Tapioca.
Rice.

3. LIGHT DIET.—A.—Any liquid food or foods on Soft Diet.

Vegetables, puree of.
Potatoes, baked or mashed.
Rice.
Desserts: Tapioca, rice, cornstarch puddings, prune whip.
Bread: White and whole wheat.
Fruits: Fresh and stewed; baked apples.
Jellies and preserves.

4. LIGHT DIET—B.—Light Diet A with the addition of:

Meats: Chicken.
Sweet breads.
Lamb chops.
Tender steak.
Fish and oysters.
All cooked vegetables.

5. GENERAL HOSPITAL DIET.—

Breakfast:

Orange, grapefruit, berries or other fresh fruits.
Stewed fruits.
Shredded wheat biscuits, Dr. Price's All-grain Food, Ralston's Breakfast Food, rolled oats, bran or cracked wheat, with cream and little sugar.
Eggs, soft cooked, seven minutes or poached.
Corn muffins, graham muffins with butter and honey, syrup.
White bread, toast, Vienna rolls.
One cup coffee or cup of cocoa or glass of hot water and cream.

Dinner:

Creamed vegetable soup. Meat broths. Meat soups without fat. Roast beef, roast lamb, roast chicken, roast turkey without dressing. Cranberry jelly. Fruit jellies.
Stewed chicken, stew lamb. Boiled and baked ham.
Broiled steak, broiled lamb chops. Fresh fish, baked.
Stewed or baked white onions, cauliflower, peas, corn, lima beans, okra, stewed or baked tomatoes, baked or broiled egg plant, artichokes, beets, oyster plant, carrots, spinach, asparagus, string beans, well mashed turnips, stewed celery.
Raw tender celery, ripe olives.
Potatoes well mashed, baked or creamed. Rice well cooked.
White, graham, whole wheat, rye, or corn bread or toast. Vienna rolls, corn muffins with butter, honey and syrup.
Lettuce, tomato and fruit salads with French or Mayonnaise dressing. Crackers. Cheese. Stewed fruits. Raw fruits.

Custards, gelatines, cornstarches, tapioca, junket, prune whip, blanc mange.

Soft vanilla ice cream. Light cakes, such as sunshine or sponge cake.

English walnuts, pecans, raisins, dates, figs.

Bulgarian milk, hot water and cream or cool water.

Supper:

Mixed vegetable soups. Creamed vegetable soups.

Spaghetti. Schmier Kase. Boston baked beans.

Eggs: poached, soft cooked, omelet.

Vegetables same as at lunch.

White, graham, whole wheat, rye, or corn bread or toast, Vienna rolls, corn muffins with butter, honey or syrup.

Stewed fruits. Raw fruits.

Custards, gelatines, cornstarches, tapioca, blanc mange, prune whip, junket.

Bulgarian milk, glass of hot water and cream or cool water.

6. Diabetic Diet (Allen-Joslin).—Diet arranged with dietitian to meet individual requirements. Amount of carbohydrate, protein and fat, and the number of calories to be specified by the physician, and worked out in detail by the dietitian.

7. Low Proteid Diet.—Cereals: Oatmeal, shredded wheat biscuit, Ralston's Breakfast Food. Dr. Price's All-grain Food, Pettijohn. With cream and sugar.

Bread: Whole wheat, Graham, rye, corn bread (coarse meal); Graham rolls, bran biscuits, Graham crackers, Educators, Triscuit. With cream and sugar.

Green Vegetables: Spinach, asparagus, egg plant, oyster plant, carrots, beets, beet greens, cauliflower, cabbage, Brussels sprouts, squash, baked pumpkin, gumbo, green peas, lettuce, tomatoes, rhubarb, kohlrabi.

Starchy Vegetables: Potatoes, rice, spaghetti, hominy grits.

Stewed Fruits: Peaches, pears, apricots, plums, prunes, cherries, cranberries, berries of all sorts, figs, apples, apple sauce, baked apples. Canned fruits are satisfactory if re-

cooked. No preserves. Fruit jellies. Oranges and grapefruit but no other uncooked fruits.—Journal of Mo. Med. Ass.

THE MANITOBA HOSPITAL ASSOCIATION

The Annual Meeting of the Manitoba Hospital Association will be held at the Medical College of the Manitoba University, Emily and Bonnatyne Ave. Winnipeg, on Monday and Tuesday, 7th and 8th, November, 1921.

The programme will consist of Short Papers on matters of live interest to Hospitals, both large and small. Plenty of time will be allowed for discussing such questions as:— "The Modern Hospital and Its Relation to the Community." (In this connection the "Modern Hospital" does not depend upon its size). "The Professional Work of the Hospital" and what is meant by "Hospital Standardization." "Hospital Finances," Legislation and Government aid to Hospitals. "Hospital Accounting and Purchasing," "Nursing Problems," "Affiliation of Training Schools," Exhibit of Hospital Equipment.

Members should be thinking over the problems upon which they desire information. Bring your questions with you, or what is more preferable, mail them to the Secretary, so that time may be given to prepare proper replies.

While primarily designed for hospital trustees and executives it is desired that everyone interested in hospital work should attend. The importance of your hospital in your community should concern everybody. Improvements and progress in your hospital comes through the increased knowledge and skill of the superintendent and staff, from co-operation and team work amongst hospitals and it is to your interest to bring this about.

Above all your superintendent should be present. The inspiration that she or he will get from meeting others who are doing hospital work, and whose problems are very much the same as yours, will more than compensate your institution for the time and money expended.

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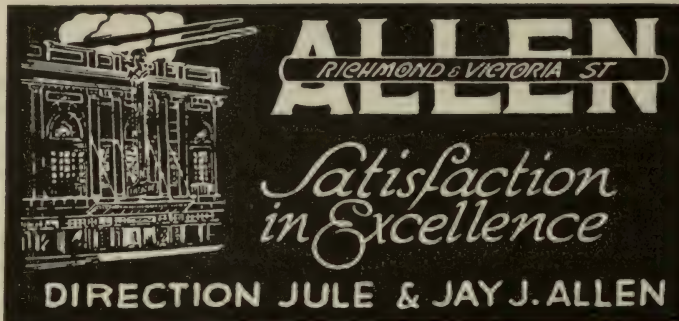
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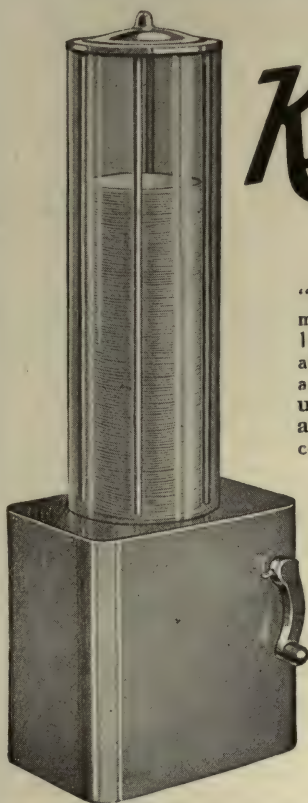
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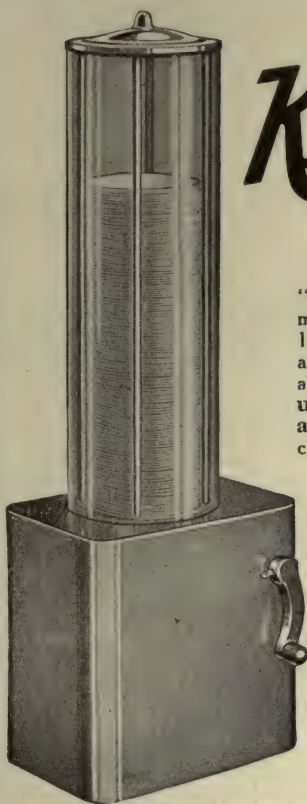
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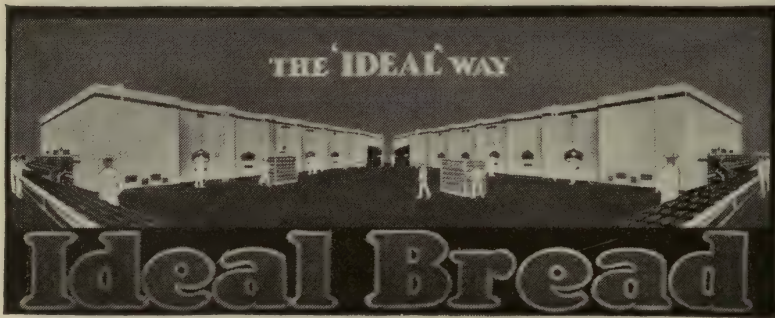
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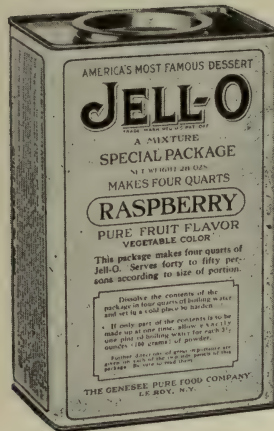
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THE HOSPITAL WORLD

Vol. XX

Toronto, December, 1921

No. 6

CONTENTS

EDITORIALS

	Page
Apprenticeship.....	155
Quiet Toronto.....	156

ORIGINAL CONTRIBUTIONS

The Hospital Interne, Robert S. Coughlin M. D.....	159
The Economic aspect of a Central Purchasing Organization for Hospital Boards.....	167
American Conference on Hospital Service, Frank Billings M. D.....	174

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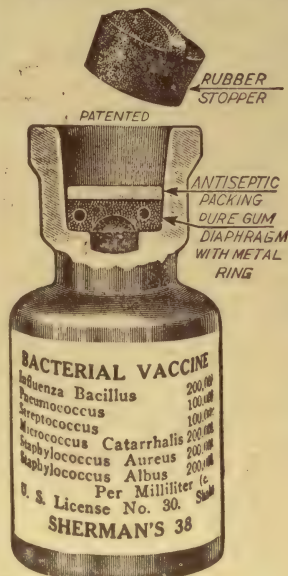
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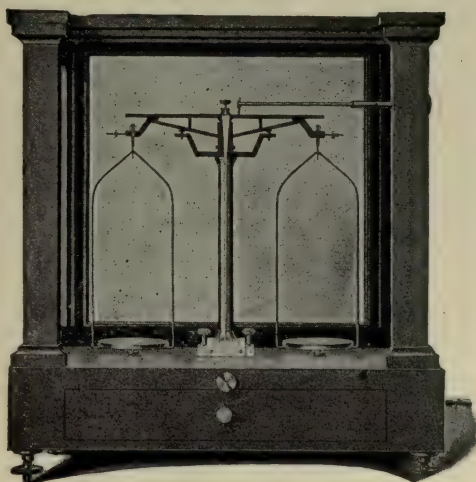
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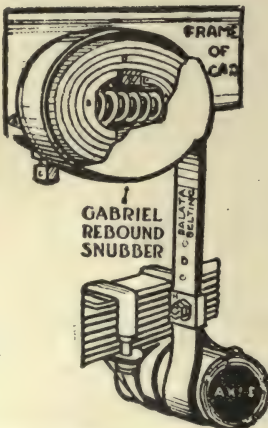
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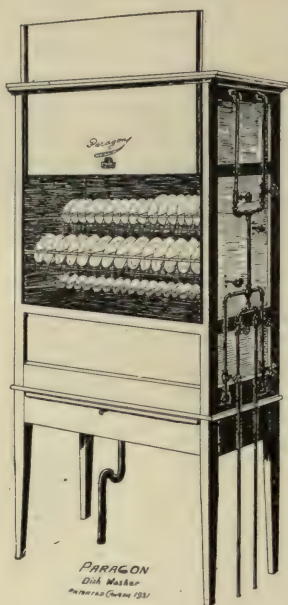
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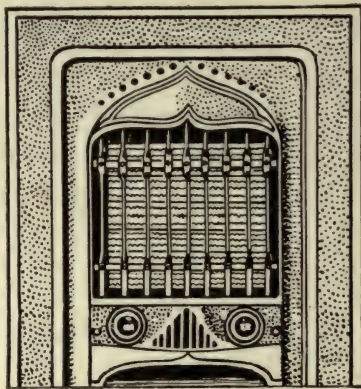
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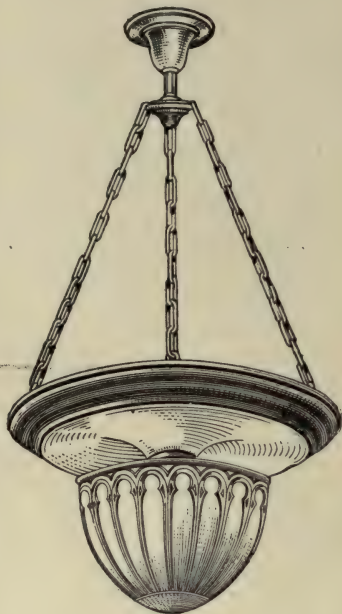
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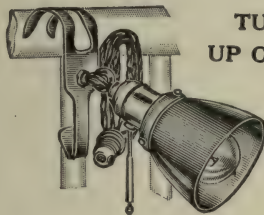
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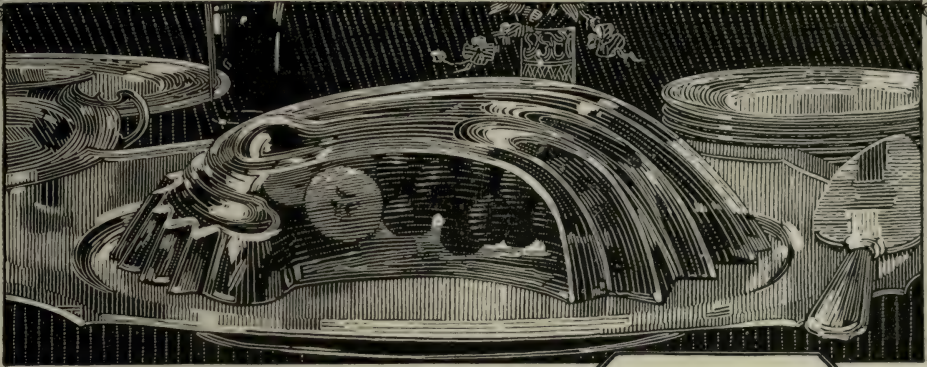
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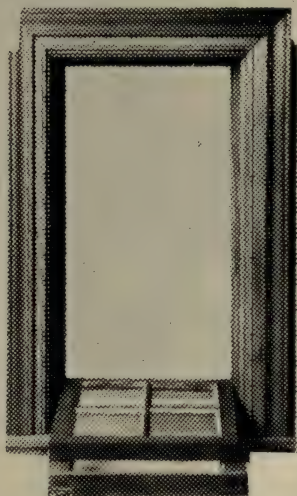
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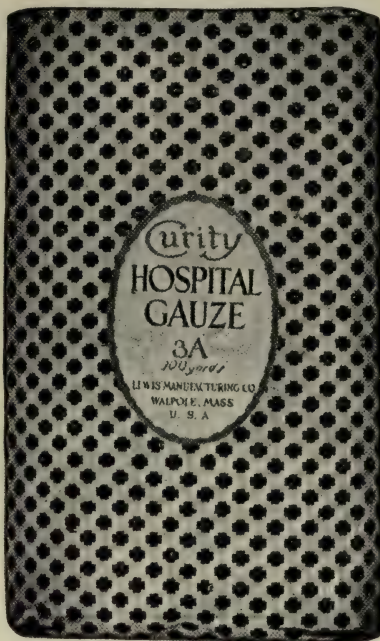
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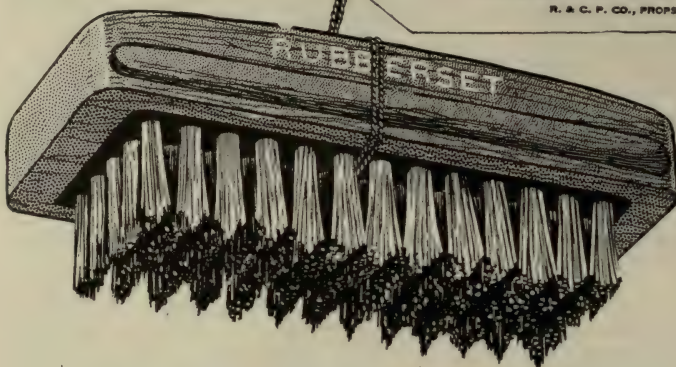
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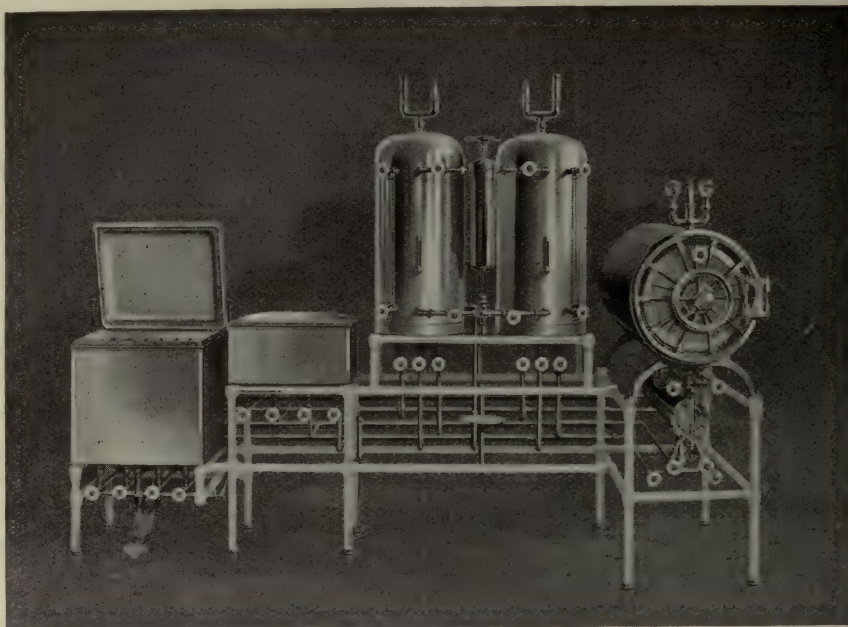
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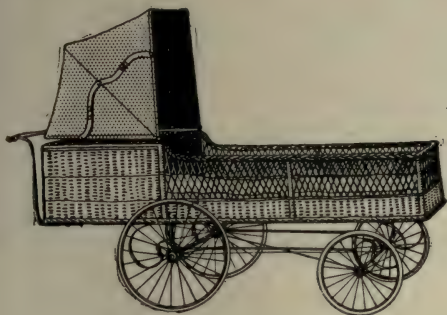
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TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums
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Dec., 1921

THE HOSPITAL WORLD

No. 6

APPRENTICESHIP

In the early days of medical teaching, the student was required to put in a certain amount of time with a practising physician. It was a good idea. This custom unfortunately has fallen into disuse. It should be revived.

Our universities are now securing full-time professors who know nothing of private practise. Nine-tenths of the men who graduate will go into general practise and they can learn a great deal by spending a year with the old-fashioned general practitioner, particularly in the smaller towns and rural localities.

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We hope the day will come when the student will again spend at least six months during his course with a doctor. This need not lengthen his course—a good vacation for him.

QUIET TORONTO

Practise in Toronto during the past summer has been quiet with many practitioners. The reasons are not far to seek. The city is over-full of medical men; about a thousand it is estimated. Some of these men are partially retired. Having made a fair amount in outlying places, they seek the city to give their children the opportunity of attending college and at the same time have them under the parental roof. These men are satisfied with a limited amount of practise and small "takings." Then there is a number of the younger men who have been given minor appointments on the medical faculty of the University. These are prepared to work and wait. Some of them have means, others have not, but are struggling along, looking for better days. They may after working little—and—have a bitter dose in store.

The rank and file of men who are bearing the burden and heat of the day are paying their rents, interest, insurance and other expenses, and laying up

treasures—not in this world. We believe if they spent the same energy and devotion to some business or to farming they would be richer men—richer in this world's goods. Many of them would be better off financially did they charge more for their services, did they send bills more promptly and were they more businesslike in their methods.

Then there are the favored few with good training, good connections, well married, who are laying aside a few dollars with which, after they “do their stunt,” they may retire in **otium cum dignitate**.

In addition to the overcrowding Toronto's excellent Civic Health service is cutting many doctors out of work. The examination of school children, the visits of public health nurses to thousands of homes, the well-baby clinics—all tend to lessen the labors of the general profession. This is as it should be and no doctor complains about it. But the overcrowding of the profession is something to bemoan, especially when one considers how scarce doctors are in some of the country districts and frontier localities.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

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THE HOSPITAL INTERNE

Robert E. Coughlin, M.D.
Brooklyn, New York.

In all probability the hospital interne was created because of necessity. No one appears to know how or where he originated. Probably the first hospital had no interne. As time went on it appeared wise to have some medical representative close on hand for the sick and injured. Under the present conditions the hospital interne is absolutely indispensable. He is possibly a more important part of the hospital machinery than is generally realized. Depending upon the point of view he occupies an exalted or a subordinate position. He occupies an intermediate position between the hospital management and the visiting staff on one side and the nursing staff on the other.

First let us consider the question from the standpoint of the boards of directors or the governing body. Second from the viewpoint of the visiting staff. Third from the standpoint of the interne. After considering these different points, we may come to a conclusion as to a mode or plan to obviate existing evils.

From the viewpoint of the board of directors the interne is regarded in the same way as a student taking a post-graduate course. They believe he should command respect as any graduate of medicine should. In their minds he is in the hospital to learn and serve. His service is indispensable for the reason that he has made it so by his work in the past, and because the visiting staff so regard him. The opinion obtains that the average interne is pushed away during the time of the operation, and during the time subsequent to the operation or the post-operative period he is delegated too much responsibility as regards the patient's welfare. Their criticism of him would be that he is overbearing to the other inmates of the institution, that he is too jealous of his degree of Medical Doctor, that he dominates the rest of the working staff in the hospital, that he is up on his dignity at all times, that he draws his lines of duty too finely, and that there is little reciprocity between the different members of the interne staff. In other words,

there is little elasticity, little give and take.

From the viewpoint of the visiting staff, the hospital interne is considered all the way from a useful adjunct to a necessary nuisance, according to the personal equation involved. The truth must be told that as a rule the interne is regarded more in the light of a worker or helper. A certain amount of work is to be gotten out of him as per orders of the visiting staff. Histories are to be written, preliminary examinations to be made, preparations for the operative procedures, etc. It is rarely that an interne is regarded as a student. At the time of the operation he is seldom taught the technique or steps of the operation by the operator. When the operator talks, he talks to his first or second assistant, or to the spectators, never or hardly ever to the one man at the operation who is giving all his time and attention to the pursuit of learning. After the patient is on the table, the interne is pushed aside in favor of one, two or more assistants. After the operation the patient is again on his hands for post-operative dressings and care. Even at this time he is given scant instruction by the visiting staff, to the detriment of the patient's chances for recovery. On the medical side the medical attendant, while he insists upon having the interne make the rounds with him, gives him scant attention during his rounds. It is seldom that he takes the time to instruct him on the different interesting points in the case record. Many times the nurse is addressed in preference to the interne, which of course is a rank discourtesy to him. When all is said and done, we must be forced to the conclusion that many evils of the interne system can be attributed to the sins of commission and omission on the part of our visiting hospital staffs. They are responsible for the existence of the interne in the first place, but their paternal interest in the interne is not in proportion to the responsibilities imposed on the interne during critical times when the patient's life weighs in the balance as often happens after an operation has been performed, or during the crisis of a serious illness. It is in the power of any visiting staff to awaken and keep alive intense enthusiasm in the interne. He will be the willing worker at all times, but the visiting attendant must have and show enthusiasm before he can inject it into others. He must also show a particular interest and regard for his house surgeon or house physician. Until this condition of affairs obtains we shall always have the problem of the interne

question to solve.

From the viewpoint of the hospital interne we can do no better than to quote from an article in the Southern Hospital Record for July by Dr. Emory Park, who speaks a few words on behalf of the resident physician or interne. Some of his statements should be quoted and applauded: "The hospital should not demand that the interne write all the histories and do the other detail work and then step aside when the operations are performed, and let some outsider be the assistant at the operation." "Some hospitals let inconsiderate members of their visiting staff call residents away from their meals or let them set their operations at that time as will make the interne either miss a meal or choke it down in hunks." "They should be well fed and provided with clean, comfortable rooms and bathrooms."

In an editorial comment on this particular article, the New York Medical Record of October 21, 1916, states as follows: "Internes seldom receive any money except in some instances a nominal sum. The tacit arrangement in vogue is in the nature of a fair exchange. The hospital receives service which is in reality indispensable, each patient is visited once, twice, or more times a day, routine dressings are done and the feeling is that the patients are protected, that there is for twenty-four hours a day a staff of trained men on guard, capable of interpreting symptoms and knowing when to call in the more experienced physicians. They may be likened indeed to the outposts of an army camp. They recognize danger at a distance, and it can be repulsed before it threatens the heart of the army itself, so the general sleeps more soundly in his tent, just as the famous surgeon is able now and then to take a week-end, knowing that Smith and Jones at the hospital will not have him called needlessly, but also that they will not let any of his patients die for want of attendance. In return for these services the interne expects and should receive experience, not the facility of inscribing 'Mag, Sulph. zi' in the order book until he wakes from dreams writing it in the air, not the holding of the surgeon's coat while he puts on a plaster cast, and not the bird's eye view of the operation as the third assistant, but the actual diagnosis and treatment of cases, the administration of anaesthetics, and the performance of operations. For each interne in his hospital each member of the visiting staff should feel the kindly interest which the old-time pre-

ceptor had for his pupil.

"We do not favor the loosing of a recent graduate, full of theory, but deficient in practice, upon wards of helpless sufferers. But certainly the interne should have free scope with his stethoscope in the wards, and he should be allowed to give anaesthetics at first under supervision, but later alone, and there is no reason why he should not be first assistant at operations, and even do a large part of them himself.

"Many hospitals and diverse ideals of management pass before our eyes as the years go by. We have seen hospitals where anaesthetists were called in from the outside to serve in rotation to the exclusion of the resident staff, where each surgeon seemed to have always some protege whom he brought into operations to act as first assistant while the interne who had examined the case, prepared it for operation, and would later carry it through the miseries of the post-operative period, stood around and passed instruments. We have seen hospitals where the tip went forth to potential candidates that the food was bad, thus frightening away many a good man. Another where the doctors' home consisted of a ramshackle frame building, at which prospective internes took one look and fled. As Dr. Park reminds us in his article the hospital interne is not only a highly and specially educated person, but he is a gentleman. He is entitled to treatment accorded a gentleman anywhere and, in addition to the full amount of consideration for which he gives his services, that is all the experience the hospital affords together with the advice and the oversight of the older men attached to the hospital staff. The hospital period is probably the most valuable of the young doctor's training, if he is fortunate enough to get into the right sort of a hospital, and with a little friendly co-operation by those responsible for the management of the hospitals all of them would be made desirable in this regard."

The following evils of the interne system have presented themselves in the experience of the writer. The incidents referred to have happened within the last two years which makes them fairly up-to-date, and there is no doubt that such incidents happen at some time or another in the history of every working hospital.

One of the most annoying things is where an applicant is accepted in the Spring of the year to go on duty in December,

or January. After several candidates have been told that there were no vacancies, a letter is received from the candidate who had agreed to wait until December or January, to the effect that he had changed his mind and had decided to take a position elsewhere where he thought the service was better.

Another instance may be mentioned where an interne had served eight months' service and then with very little notice departed to another hospital, where he remained a few months and later left this institution to finally finish his internship at another institution. It was later discovered that he had "made" another institution and served there for a time before starting in to do the work at the first institution where he had served for eight months and left with little notice. To make it explicit, Dr. A. "made" the Brooklyn Hospital, served there for a time, then agreed to serve the Norwegian Hospital for an eighteen months' service, but left at the end of eight months, going to the Kings County Hospital, where he remained for a short period, finally finishing at The German Hospital.

Another instance may be cited where both the house physician and surgeon, on account of some trivial incident, packed up and left the hospital with the care of the patients entirely in the hands of the junior men. After remaining away for twenty-four hours, they saw the error of their way, and returned.

Another instance may be cited where the house surgeon left the institution entirely alone because it was his night out, the ambulance surgeon being out on call. It has been alleged that the same interne, when asked one night to take an ambulance call to attend an injured person at the nearest precinct, replied: "Not if he was Jesus Christ." At another time he told a ward patient to "go to hell," because she complained on account of his roughness. This interne was later told to resign, and to this day the interne committee have his intense enmity.

Another instance may be cited where all internes were out where there were four men on the staff, a surgical patient dying in the meantime, and the attending surgeon being called out of his bed to sign a death certificate, it being necessary to take the remains out of town for burial.

Still another instance may be mentioned where Dr. B. received his appointment at the Norwegian Hospital for an

eighteen months' service. He remained three months, and left giving a few hours' notice. He went to Bellevue Hospital, but did not complete his course there.

The following is an example of "suggestions" made by internes, to the medical staff, as to how a hospital should be run, no allowances being made for repairs necessary in the construction of a new building.

November, 1915.

"We, the internes of the Norwegian Hospital, do respectfully submit the following suggestions:

"1. There are too few internes to do the work as it should be done. This means that we must spend so much time in routine work that we are unable to do any special work or to follow cases so as to get the most out of them. Study is impossible, because our time is so greatly filled up.

"2. That our Laboratory be placed in a working condition as soon as possible. At the present time it is in a state of chaos, and we cannot use it, except for the simplest examinations.

"3. That we do unanimously recommend the inauguration of compensation for internes.

"4. That our quarters be enlivened by some form of amusement, such as a talking-machine, etc.

"Doctors A., B. and C."

In October this year it occurred to the writer that a directory of the internes in the different hospitals similar to the army and navy bulletins might be printed in one or more of our medical publications and in consequence the following letter was sent to Dr. Claude L. Wheeler, editor of The New York Medical Journal:

Dear Doctor:

For some time past I have been trying to get up a clearing house plan for internes who are located in the different hospitals in greater New York. I have communicated with the superintendents of several of our hospitals and they appear to agree that something along this line is feasible. It has occurred to me that you might help out by publishing a directory in your journal giving the names of the present house staff in each of the hospitals, his length of service, when his service

ends and who is to succeed him. One of your clerks could attend to this matter and I am sure that any of the hospitals would give you the information desired. As a business proposition I believe it might appeal to you as every recent graduate and interne begins to decide upon the medical journal to which he is to subscribe. A directory of this kind would appeal to him and would get him into the habit of reading your valuable journal. Such a scheme would in my opinion prevent internes from jumping from one hospital to another in the middle of their service as it would be generally known that they had signed up at a designated hospital.

Kindly acquaint me with your opinion in the matter at your earliest convenience, and oblige.

In answer to this letter the following was received:

Dear Dr. Coughlin:

Your letter of October 3rd presents a most interesting problem; one I do not feel I can pronounce upon at once. We shall be glad to take the matter under advisement, and if the directory of the kind you suggest did not occupy too much space, we could publish it once or oftener as circumstances might dictate. If any further suggestions occur to you, we should be glad to have them.

With regards, I remain,

Very truly yours,

Claude L. Wheeler, M.D., Editor.

Dr. Wheeler's sudden death occurred a few days after the receipt of this letter.

In conjunction with the directory idea and hoping to get some ideas about the feasibility of a clearing house for internes the writer sent a communication to forty representative hospitals in Great New York, after he had been instructed to do so by the Medical Staff of The Norwegian Hospital. There were eleven replies, about 25 per cent.

To recapitulate, the hospital interne has made himself absolutely necessary in the working of a modern hospital as we see it in operation at the present time, and that this condition of affairs has been brought about because the visiting staffs of our hospitals have catered to interne service. In all probability the hospital interne will continue to be a valuable adjunct

in the running of our hospitals in the future and that he will be considered more as a student pursuing post graduate study than as a worker in our hospital machinery. Evidence goes to show that our visiting staffs do not so regard the hospital interne, hence the trouble which always ensues when the proper appreciation of conditions does not prevail. From the facts at hand our present internes do not take their appointments seriously. Their word as gentlemen should be as good as their bond and it should not be necessary to pin them down to written contracts, much as the same seems necessary at the present time. Eleven replies to forty inquiries on such an important question shows that our hospital managers are rather apathetic on the subject. It is evident that there is more interest in the subject in the borough of Brooklyn than in all the other boroughs combined. This may be because it is considered a borough matter as they have tried a similar scheme heretofore in Manhattan. Anything that will keep our young internes from jumping from one hospital to another and anything that will make it so that a candidate will not have to wait six or nine months to go on service will be welcome. To obviate the latter trouble it would be a good plan as has been practised in a few hospitals to make all appointments in the spring and thus do away entirely with appointments beginning in the late fall and winter. The ambulance work could be performed by the senior men, helped out by the juniors, for a certain number of days each service period. Hospital service would then be either one or two years as there does not appear to be any good reason for a sixteen and eighteen months' period of service.

Conclusions

1. That the interne question is one of the most trying problems to solve today, related as it is to the nerve fibre of our hospital work and that the supply of good internes is not keeping up with the demand.

2. That it is very evident that the members of our visiting hospital staffs both individually and collectively do not take the proper attitude toward the hospital interne. In other words they fail to appreciate the real status of the interne, the visiting doctor who takes very particular pains to teach the interne being an exception to the rule.

3. The only proper attitude to assume as regards the interne is to consider him a student who is pursuing post graduate study.

4. That the position of hospital interne has much to commend itself for our consideration. The fact that the interne is such is proof that he desires to learn and appreciate his shortcomings, when it comes to the practical side of our profession. In this desire to learn he should be encouraged. On the other hand he should not draw his lines of duty too finely for the good of the hospital service and all concerned.

5. A central examining place, where all graduates coming up for hospital interne appointments within the city limits or borough limits could be examined by an examining board and candidates rated and appointed according to their rank, seems perfectly feasible.

6. A clearing house for hospital internes seems necessary.

7. A directory for hospital internes published in one of our local medical journals would be of material help.

8. Interne service in our hospitals should be either for one or two years and all appointments should be made in the spring of the year, service to begin at this time; half of the number of internes retiring or graduating as the other half lately appointed come on for service. The senior internes to be designated for ambulance service for a certain number of days and relieved when necessary by the junior men, thus complying with the rules and regulations of the ambulance service within the confines of the city limits.

THE ECONOMIC ASPECT OF A CENTRAL PURCHASING ORGANIZATION FOR HOSPITAL BOARDS

A circular has been sent to every Board covering schedules of articles most commonly used in hospitals, an attempt having been made in compiling the schedules to achieve something in the nature of a preliminary standardization as regards materials, sizes, qualities, etc. Boards have been invited to notify the Department of their requirements in order that a

consolidated order may be placed direct with the manufacturing houses with a view to bedrock prices being obtained. The articles being despatched direct from the factory to the hospital store, considerable overhead charges should be avoided, the Department further making no administrative charges for undertaking the work.

In addition to the schedules forwarded other schedules have been prepared of articles of New Zealand production with a view to quotations being obtained, of which Hospital Boards can avail themselves.

It is quite possible that the question may be raised that such action on the part of the Department is wrong in principle as being inimical to the local business houses. Such argument would be totally fallacious, and it is to emphasize the unsoundness of such reasoning that this article is written. Public institutions are entitled to buy in the cheapest market possible, and it is the duty of the representatives of the public to protect the interests of the public as a whole and not merely a small section of it.

As the law stands no person interested in a hospital contract can hold a seat upon the Board, and therefore Board members are free from any personal interest in this matter.

The argument that "the trade won't stand it" is a bogey that should hardly materialize. The trade has, it is true, expressed the view that the hospital contracts are the legitimate spoils of the retailers, and it is understood wholesale associations have in some localities decided that their members should not tender for the contracts. There are, of course, the usual hints about moving the Government in the matter; but State business enterprise, such as coal-mines, is apparently overlooked by those who think the Government would lend an ear to arguments advanced against a simple business proposition. Such opponents of the proposals apparently also overlook the combinations effected by the numerous farmers' co-operative societies—combinations for purchasing not for the retailer, but for the consumer. Objectors also overlook the fact that Australian hospitals have combined for the purpose of purchase, buying direct from the factory through a central Board of Supplies, and that no boycott or other vengeance has resulted to any one therefrom. Combination for the purpose of buying is in fact much more general and successful than combination for selling or any other purpose.

It is held by authoritative writers on economics that both competition and combination—the latter might at first sight appear the antithesis of the former—are good for the community; in fact, that all sound business actions are beneficial. "Any combination gives respite to the pressure of competition; no combination abolishes competition." Movements apparently diametrically opposed are so interwoven, and react so upon one another, that it can be taken as an axiom that any movement taken on businesslike lines to save waste, to save expense, to increase production, or for any other sane motive is beneficial to the community. So long as business is conducted on the present lines every one who can go into the market with an order large enough to obtain a wholesale quotation should be at liberty to do so. In fact, he is at liberty to do so. Business is business, and sentiment alone will not keep a seller from accepting an order. "Business is business" merely means that business is a struggle; that it is economically sound that it should be so; that though the game must be played fairly and within the rules, yet it is a hard game, and totally lacking in chivalry.

The methods of civilization thus at present follow those of nature in that there is a constant struggle for existence and only the strong survive—or, as has been expressed in other words, only those able to make the maximum sacrifices without loss of efficiency. Society has not yet found a better method of organizing its business, and there is no reason why the State should not use the same methods as it permits private individuals to use.

The buying of hospital supplies is business, and thus comes within the clutches of this conscienceless machine which is incapable of dealing with sentiment. It would be economically unsound, therefore, and so a result detrimental to the community, to deal with the question of purchasing these supplies other than from a business standpoint. Economics is only the science of business after all. Competition, association (even speculation, if by an expert and not an amateur) are closely interwoven, and are held to be legitimate and beneficial if used within reason. The person who argues against any sound business step on the ground that it is bad for existing trade organizations is as misguided as those who argue against the establishment of railways because they would prejudicially affect the stage-coach business. If such a person's advice

were followed there would be no business enterprise, and no sufficiency of varied articles of food, clothing, ornament, comfort, or means of gratifying the physical, intellectual, or aesthetic senses, which now flood the market at prices within the reach of all.

It is not our place in an article of this sort to review the whole scheme of things, to state whether the existing idea is right, or to deal with the purely ethical aspect of business: it is our province only to point out the conditions under which the community exists as a business organization, and to show that our proposals are only consistent with the existing condition of affairs.

Business, like the ocean under the influence of a wind, is always changing and never the same. That wind is competition. No matter what the surface changes are, the ocean itself remains unchanged. It is the same with business. Firms rise and fall, altered conditions make or mar fortunes, but the volume of business still remains: the work itself does not diminish—only the personnel of those employed. A man may be working for himself one day, for an association the next, for an individual firm on another occasion—then why not for the Government? Why should the State abstain? It may be true that the middleman is not necessarily a curse. Economists hold that his existence is justified provided he exists not as a toll-gate erected across a road, but as a bridge placed across a river. But there is no need for an expensive bridge if it can be avoided, and no need for a bridge at all if the river can be negotiated in any other way. It is the State's function to see that human life is preserved under decent conditions and not sacrificed to the juggernaut of commerce, to see that wage-earners are paid sufficient wages, and to see that assistance is granted to those who are not strong or efficient enough to earn such average wage; but it would be economically unsound if the State interfered to the extent of insisting that more wage-earners were employed than the business warranted. There is, therefore, no reason why, by abstaining from business itself, the State should officiously strive to keep alive the middleman. By the State itself acting as middleman no one is thrown out of employment, as buyers, clerks, &c., are still required, but the public gets the advantages of the profits, unless the bureaucratic administration—*i.e.*, administration that ties the administrator's hands and makes

him part of a cumbersome and slow-moving machine—eats up the profits in administration. But even if it did the profits would at least be more evenly distributed, not among a few wealthy men, but among a public service, practically none of the members of which could by any stretch of imagination be considered wealthy, but who form a numerous and desirable clientele and source of income to the retailer, and whose service is necessarily economic. The cost of administration by the State would in any case be returned to the public who pays or it.

Let us follow this particular matter to its logical conclusion. Let us assume that the loss of the local hospital contract is going to materially affect the local retailers—a very unlikely contingency. It must be remembered that it to the same extent benefits the local ratepayer, and the local ratepayer has consequently more money to spend with the local storekeepers; so the position as regards the retailer remains as before, but the ratepayer, besides saving money, also gets a choice in the spending of his money.*

*Take for example the case of a runholder whose hospital rate is 50 pounds a year. By economy in hospital administration his rate is reduced to 40 pounds. With the 10 pounds saved he can purchase a suit of clothes from the local outfitter. "No," he says, "I will use the 10 pounds, together with further rates I have saved through improved public service, in purchasing stud rams to improve my flock." "Ah," exclaims the local retailer, "then I do not get the money after all." Wait a bit. As a result of the improvement of his flock the squatter realizes considerably more on his wool-clip, and indulges in a regular debauch of clothes, resulting from an increase in income, the money comprising which does not come from within the Dominion but from without, and is thus an actual addition to the wealth of the country. Thus the hospital benefits, the retailer benefits, and we trust the enterprising public servant will not be a loser; which proves the contention that all sound business enterprise is good for the community and also that all enterprise is so interwoven and interrelated that if the undertaking is sound beneficial results must follow).

Why, therefore, should a crude method of purchasing be continued when by combination not only can better prices be obtained, but further advantages, such as reduction in

freights and other rebates, can be obtained, such charges being in inverse ratio to the size of the consignment?

The profits, moreover, which are saved would otherwise accrue not necessarily to New Zealand firms, but to shippers at the other end, and would thus be lost to the community here. Further, the moral effect upon hospital administrators would be beneficial. Goods purchased on a scientific and economical basis are more likely to be used in a scientific and economical manner than goods purchased as required in a hand-to-mouth manner. Local administrative officers learn to estimate their requirements, to question their estimates, and review the actuality and reasonableness of their needs from such estimates; in fact, a scientific and proper spirit of organization and administration is inculcated, and co-operation in this direction should lead to further co-operation, standardization, and the elimination of waste.

The cost of our institutions is high, and is growing yearly to an alarming extent. This *Journal* has pointed out from time to time directions in which the local Hospital Boards could restrain such expenditure, or at least offset it, by systematic efforts in the collection of revenue such as patients' fees. The Department foresees a great outcry amongst the contributory local authorities after the 31st March, when the levies are made for the ensuing year. It is extremely probable that the levies will be heavier than ever, as many Boards will have to add heavy current overdrafts for maintenance expenditure to their already heavy estimated requirements. Boards, therefore, must be prepared to face considerable criticism, and will do well to see that their houses are in order and their administrative methods above reproach. Moreover, the Department as contributing approximately half of Boards' financial requirements is itself interested in the matter, and cannot contribute its subsidy to be spent otherwise than in a sound and businesslike manner. It is in fact not anticipated that Boards as a whole will do other than welcome the proposal. It was the Wellington Board that in 1917 called a conference of other Boards which passed a resolution in favour of the Department initiating a system of combined purchasing, and this action of the Department is only the result of such conference, the delay in taking the necessary steps being caused by the pressure of work resulting from the influenza epidemic, shortage of staff, changes, and reorganization.

Finally, it is hoped that all those large Boards who are in a position to buy more or less direct from the manufacturers themselves will unselfishly agree to throw their orders in with the others so as to help their less fortunate neighbours.—
Journal of Public Health.

AMERICAN CONFERENCE ON HOSPITAL SERVICE

By **Frank Billings, M.D.**, Dean, Rush Medical College, Chicago

Since the first meeting of this Conference on September 9-12, 1919, at Cincinnati, the incorporation of the American Conference on Hospital Service has been perfected in Illinois and headquarters have been established in Chicago. Many of you who are here today are to be congratulated upon the fact that it was through your influence and active cooperation that this Conference has become an established fact.

It has been an illuminating privilege to read the papers and discussions presented by the representatives of the national organizations which constitute the Conference and of other individuals who are interested in the improvement of hospital service, which took place at the conference on hospital standardization held in Chicago on April 21, 1919, and at the first meeting of this Conference at Cincinnati last September.

Those who were present at these conferences or who read the proceedings of the meetings must be impressed with the unanimity of the expressed sentiment in regard to the need of cooperative and coordinated effort of all agencies engaged in the work of improvement of hospital and of service to patients. The United States and Canada are fortunate in having so many citizens of high ideals, splendid vision, and above all a common desire to improve the medical care of the sick and injured, disregarding of the too frequent causes of non-cooperation through differences engendered by sex, race, religion, politics, rivalry in professional organizations, and the like.

Supported by the constant organizations, by other corporations and by individuals, the Conference as a going agency is in a position to function and to grow and develop into greater usefulness with each succeeding year.

The *Hospital Library and Service Bureau* has been organized by a very live committee. A director has been secured who, with the needed clerical assistants, is already engaged in collecting, compiling, and indexing data along the lines enumerated in an admirable brief formulated by your vice president, Dr. A. R. Warner. I quote from his article, "The purpose and Scope of the Library."

The proposed library and service bureau will collect, classify for reference use, and distribute types of data as outlined below. Pamphlets and data will also be collected and filed in such form as to be readily available to make up bundles to be sent out in answer to inquiries.

(1) Plans, drawings, and other data pertaining to the construction of hospitals, dispensaries, first aid rooms, etc. Also follow-up of all new hospitals within one year of their opening for the purpose of appraising efficiency and adaptability of architectural arrangement.

(2) Complete record of hospital architects with lists of hospitals planned by them.

(3) Records of equipment in new hospitals, dispensaries, etc., and a follow-up for the purpose of ascertaining what part of the equipment proved unnecessary and what additional equipment was found necessary.

(4) Indexes of hospital supplies and equipment, and equipment necessary for certain work with cost estimates.

(5) Case record systems with discussions and comparative data.

(6) Health and hospital literature and reference material on community problems, vital statistics, social service, public health nursing, legal subjects, new laws and pending legislation affecting hospitals.

(7) Material and data concerning preliminary educational and publicity work incident to the promotion of hospitals. Data on preliminary work incident to the promotion

of hospitals. Data on preliminary and permanent organization of hospital boards and information regarding methods of business organization and financing.

(8) Lists of names of suitable and desirable persons with the records of their work will be kept available for those desiring to employ persons for special work, as for various surveys, campaigns etc., and for expert advice on various subjects.

(9) Complete records of all organizations and associations in the hospital-health field, with names of officials, information as to purposes, scope, and places of meeting.

(10) Information as to internal organization and management and function and work of the various departments.

Clientele to be served:

(1) Hospital, medical, nursing and health organizations and publications; and the trustees, organizers and proprietors of these.

(2) Hospital organizers, trustees, superintendents, medical staff members, department heads and other executives in official capacity or as individuals.

(3) Building committees and committees organized for the promotion of a hospital project.

(4) Directors of dispensaries and first aid workers in industries, schools and colleges.

(5) Architects.

(6) Public officials.

(7) Others having practical needs.

Principles and Policies of the Conference

The chief object I have in view today is to present to you some of the apparent principles and policies which must govern the Conference in its relation to the constituent membership organizations and to the public. These I offer as suggestions for discussion, with the hope that definite principles and policies will be adopted for the guidance of the members and administrative offices until such time as changed conditions may require their modification.

I think we are all in agreement with the statement expressed by some speakers in former conferences that the *welfare of the patient and his adequate treatment is the chief obligation of the hospital*. Disease and injury prevention are very important; but in spite of the most efficient application of the best plans of modern sanitary science to disease and injury prevention, we shall have with us always the ill and injured people who require hospital care. Therefore, for the present, the main principle of this Conference should be that expressed in the attempt to improve and secure adequate hospital service for the sick and injured.

The second principle is necessarily closely related, as it implies the obligation of the hospital as the health center of the community it serves.

Its organization should contemplate an out-patient department for ambulatory treatment, social medical care of convalescents and of others, prenatal and maternity instruction, infant and child welfare and the like. It should become a school of instruction on all of the subjects in which it functions, to its own personnel and on health matters to the public it serves. Not all hospitals may be at once developed upon the lines of the second principle, but as the first principle is applied, the second should be contemplated as a necessary factor of the hospital organization if it is to fulfill its full obligation to the public.

In the attempt to apply these principles, what policies and methods of procedure shall the Conference adopt?

In the discussion at former conferences much was said of the standardization of hospitals,—mainly with the idea of the accomplishment of what I have attempted to formulate as the first principle. The American College of Surgeons has established a minimum standard. This standard deals chiefly with the character of the medical staff; the organization of the staff, making, classifying, and filing complete clinical records of each patient; regular staff meetings not less frequent than once a month, in which the clinical records shall be the basis of discussion, analysis, and review, and requiring the hospital to maintain laboratory facilities, chemical bacteriological, serological, radiographic, and fluoroscopic, with a personnel of qualified technicians. This standard has been accepted by many hospitals. The American Medical

Association, through the Council on Medical Education after years of investigation has collected, classified, filed, and published data in the *Journal*, with lists of hospitals rated upon certain required factors, as offering sufficiently good opportunity for interne service and, therefore, classified as approved by the Council. Other constituent organizations have secured data of importance relating to hospitals and hospital service in regard to nurses' training schools, medical social service, out-patient departments, diseases and injuries due to industrial pursuits, the hospital in relation to the employer, the employee, and the Workmen's Compensation Act, and much other information relating to adequate treatment of the hospital patient.

The minimum standard fixed by the American College of Surgeons, the required conditions for the rating of hospitals by the American Medical Association to become listed as approved for interne service, the standard fixed for the curriculum and years of hospital training by certain training schools for nurses, are in the main satisfying from the point of view of those interested in institutions which are able to meet the requirements without embarrassment to finances and personnel.

It is evidence to us all, I think, that it will be impossible to fix a minimum standard for hospitals which meet the requirements of the first principle named (adequate treatment of the patient) which will be accepted at once by the majority of the small hospitals (those with less than 100 beds) of the country. Therefore, I believe it should be a policy of the Conference to formulate the essential minimum requirements of hospital organizations, to correspond with the first principle, through a committee composed of one or more representatives of the constituent organizations. In a consideration of these minimum requirements the committee will doubtless accept, with or without modification, the minimum standard fixed by the American College of Surgeons, the American Medical Association, and other constituent organizations. We shall all agree, too, I believe, that while these minimum requirements must conform with the conditions which will insure adequate treatment of the patient, they must be practical and of a character which will permit their acceptance by all hospitals within a reasonable period of time. For those hospitals which function in the training of medical students, in-

ternes, and nurses the minimum requirements must necessarily include factors which are not essential to the large number of hospitals which are not connected with medical schools and do not embody the training of nurses.

If the Conference adopt these suggested methods of formulating the factors of minimum requirements for the standardization of hospitals, I ask consideration of principles and policies to govern the methods of procedure which must be taken up coincidentally with or immediately following the conclusions of the Committee or Standardization.

The principle involved is fundamental if we are to obtain the object sought. It involves practical cooperation and coordination of effort of all the constituent organizations of the Conference in their adopted respective fields of work for hospital betterment. I would suggest that the policy to be pursued under this principle shall be the agreement upon the part of each constituent organization to continue in its elected field of investigation of, and the improvement of, the involved factors of hospital betterment. For example, the American College of Surgeons is chiefly interested in the elevation of the standards of surgical practice; the Council on Medical Education and Hospitals is chiefly engaged in the attempt to improve the standards of hospitals which function in medical teaching, including the fifth or interner year; the State Medical Licensing Board and the Association of American Medical Colleges are also chiefly interested in the same object; the American Nurses' Association is chiefly interested in the maintenance of high standards of its training schools and in the legal licensure of nurses; the Catholic Hospital Association of the United States and Canada is chiefly interested in the improvement of hospitals and of service in those institutions conducted by the Brotherhoods and by the Sisterhoods of the Church; the American Hospital Association has a wider field of endeavor, including standardization of hospital administration, plans for hospital buildings, materials of construction, types of hospitals and organizations suitable for different communities, and the like; and other constituent organizations have their own particular problems to meet. All are fundamentally interested in the improvement of hospitals to the end that adequate treatment may be given the patients.

It will be an economy of time and money if this policy of cooperation include avoidance of duplication of the work of investigation, whether this be of personal visitation, by questionnaires sent through the mail, or by other methods.

I would also suggest the further cooperation of the members of the Conference by the adoption of a policy which will make the *Hospital Library and Service Bureau* the repository and clearing house of all data concerning hospitals which may be obtained by each constituent organization in its respective field of work. Each organization may keep, if it so elect, files of its own acquired data, copies of which should be sent to the library at headquarters of the Conference in Chicago. This data would then be properly classified and filed. It is understood, of course, that the personnel at the headquarters of the Conference will be engaged in securing, classifying, and filing data concerning hospitals which must be secured through its own initiative. The data which the personnel at headquarters may collect from various sources outside of the organizations which constitute the Conference are enumerated above in the quotation from the brief prepared by Dr. A. R. Warner. The accumulated data are owned by the Conference,—that is, in reality owned by the constituent membership, and are readily available for the use of all.

To the end that the policy of cooperation in the field of investigation of hospitals may be carried on economically and efficiently, I would suggest the appointment of a committee composed of representatives of the constituent organizations of the Conference to formulate methods of investigation, to standardize methods, to assign, with the consent of each, the field of investigation of each constituent organization and so to plan the investigation of the whole hospital field that duplication of work will be avoided as far as may be possible.

“Walking the Hospitals” in London

This familiar phrase reflects the importance which the London medical schools attach to bedside teaching. These schools show traces of the earlier regime of apprenticeship and of private organization. A group of physicians who form the staff of a hospital conduct bedside and dispensary instruction. The medical school, recognizing that laboratory train-

ing in anatomy, physiology, bacteriology, pathology, and other subjects is essential, appoints specialists who teach, for the most part in a specifically practical way, the sciences and arts which bear upon the care of the sick.

In course of time, mainly out of students' fees, these hospital schools have furnished themselves with teaching laboratories in the essential medical sciences, but they have not had the funds with which to provide for the laboratory sciences buildings, equipment, or staff on what may be called a university basis. The courses have been as a rule restricted to a somewhat narrow but thorough drilling in those phases of the subjects which are immediately applicable to the making of the practitioner. English students who desired a more fundamental and general laboratory training have usually resorted to the older universities, where physiology and chemistry, especially, have been developed by a succession of great teachers and investigators. Thus the English medical school does not typically combine both university and professional work to the same extent as is the case in Germany and to some degree in the best schools of the United States and Canada. There is reason to believe that this separation between university laboratory training and bedside teaching is detrimental to both.

It is true, however, that the British schools have developed a system by which the future practitioner is given a thorough practical training in the wards and in the dispensary. As a *dresser* and *clinical clerk* the English medical student, under the close supervision of the staff, renders service to the patient, makes first-hand examinations, and assumes responsibility to an extent not equaled anywhere else in the world. This system is, so far as bedside teaching goes, the most significant contribution of British schools to the problem of training the doctor. It is an outgrowth of the apprenticeship idea at its best. The *clerkship* is, however, not the sole contribution of British medicine to modern medical education. Equally original and stimulating is the conception of individual laboratory training, which, beginning in physiology, has now spread to all the laboratory subjects.

In London as elsewhere there has been of late a demand for teachers whose chief, even sole, responsibility shall be for bedside instruction and research in the hospital. Although in every generation able English physicians have taught

students and investigated disease with brilliant success, it has become increasingly clear that doctors who give themselves primarily to private and consulting practice cannot alone successfully meet the needs of students or the demands of research under modern conditions. The Royal Commission on University Education in London, reporting in 1913, strongly urged the introduction of clean-cut university standards and ideals into the clinical departments of the London schools. This suggestion, together with other influences and considerations, led the British Government in January, 1920, to begin an experiment in the field of full-time clinical teaching. By grants of public funds *units* were established in four of the London schools. The *unit* consists of a salaried chief and two assistants in medicine or surgery who give their entire time to teaching and investigation in the hospital. The head of the *unit* was conceived as a university professor.

University College Hospital

The medical schools of London have, then, in the main, developed as professional schools for the training of practitioners, more or less cut off from the productive centres of medical science and from university control and influence. This is not to deny that many of these schools have enlisted the services of notable men, have made important contributions to medical knowledge, and have given an effective practical training. But at best these hospital schools, whose clinical teachers were generally prominent consultants, could not create the richer and more stimulating environment that has come to be essential in a university medical school.

The one partial exception to the London type is University College Hospital Medical School, which, as originally established in 1828, was in form a unified university school, with a hospital built primarily for teaching purposes. The medical sciences—physiology, chemistry, and after a while even pharmacology—were developed within University College; the clinical staff, too, was created by University College, though in composition it did not essentially differ from that of the hospital schools.

In 1904, to meet requirements of the University of London, the school was separated into two faculties, and the hospital was put under an independent board. While this did not destroy the geographical unity of the laboratories and the hos-

pital, the change did not make for that community of interest and that constant comradeship among laboratory scientists and bedside teachers which are now deemed so desirable.

In 1919 several causes combined to precipitate a new movement at University College and Hospital. The war had broken the "cake of custom"; a number of able and alert men in both faculties were eager to take a forward step; two *units* of full-time professors had been planned for the hospital; a scheme for expansion in both buildings and teaching staff was being discussed. Moreover, if something were not done, there was danger that important men would accept attractive appointments elsewhere. The posture of affairs was almost critical. Should University College Hospital Medical School return to its original form as far as possible and consciously develop the possibilities inherent therein, seeking a real unity, or should it drift with the tide?

A Gift to British Medicine

At this juncture two representatives of the Rockefeller Foundation arrived in London on their way to the continent. Recognizing the possibilities of the University College and of the Hospital and Medical School, the Americans suggested that the Foundation might lend a hand. Tentative plans were worked out and provisional estimates were made. In February the trustees of the Foundation considered these preliminary proposals, expressed an interest in them, and invited the authorities of the College and of the Hospital and Medical School to send a joint committee to the United States. As a result of subsequent negotiations the trustees authorized in May the concluding of an agreement by which the Foundation promised to contribute about five million dollars toward the realization of the new plans of the University College groups.

This sum is almost equally divided between buildings and endowment for increased educational and research activities. The more important items in the building scheme are: an institute of anatomy, a lying-in pavilion for 60 patients, a home for nurses, a house for resident physicians, and the remodeling of the hospital to provide additional beds, clinical laboratories, and new operating suites. When the work is completed, this medical centre will have an admirable modern plant and equipment, with a fully controlled hospital of 500 beds and a large out-patient department.

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JAMES BENTLEY, M.B., B.S.(Edin):—Some Illustrative Cases of Ductless Gland Therapy in the Insane (Medical Journal of Australia) May 14, 1921.

The following cases were published in order to stimulate others to investigate this line of treatment. Bentley's work was encouraged by that of Deorgum & Ellis whose post mortem findings in eight cases of dementia precox were in keeping with the inference that anomalies exist in the ductless glands in dementia precox. Dr. Bentley did his chief work with the accelerator group which consists of thyroid, pituitary, adrenal and reproductive glands, but he intends, in the future, to try the retarding group (pancreas, parathyroid and possibly the thymus) in maniacal cases.

CASE 1. B.L.A., aged 28, admitted May 31, 1919, lay listlessly in bed and paid no attention to his surroundings. He would not reply to questions, although he showed that he understood what was said to him by protruding his tongue when asked to do so. On June 15, 1919, he was in a cataleptic condition. He refused food at times. On September 9, 1919, he was put on hormotone, and ten days afterwards he spoke a little for the first time since admission. On December 29, 1919, he was discharged as recovered and has worked on a farm since discharge.

CASE 2. F.H. aged 44, on admission on December 2, 1919, depressed and would reply to questions only in monosyllables. He was very confused and slept badly. He heard a voice which talked to him continually, but he did not know to whom it belonged. He refused food at times. One week after admission he was in a state of catalepsy.

On December 20, 1919, he was put on hormotone and a week later the cataleptic condition had disappeared. He was discharged as recovered on May 26, 1919.

CASE 3. E.S., aged 35, admitted July 7, 1916. He remained in a negativistic state, rarely speaking, apparently not taking much interest in his surroundings.



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CASE 4. J.P., aged 45, admitted November 19, 1919. A case of acute melancholia. He had hallucinations of sight; he said he saw blacks and others chasing him and that he galloped his horse for two miles until the horse became exhausted. He was very depressed and miserable, and he slept badly. In May he was still very worried and unhappy and had suicidal tendencies.

He was put on hormotone on June 1, 1920 and was discharged as recovered November, 1920.

CASE 5. Aged 11, a sporadic cretin, at first put on thyroid, but did not make much headway. About two months later he was put on hormotone, and he began to improve mentally and physically. When hormotone was unobtainable he was again put on thyroid, whereupon he deteriorated mentally and physically; he became very dull and the collar of fat returned. When hormotone was again procurable he made considerable improvement. This case was a peculiar one, inasmuch as, according to the accepted knowledge, he should have improved on thyroid, whereas this was not the case. He improved only under treatment with hormotone.

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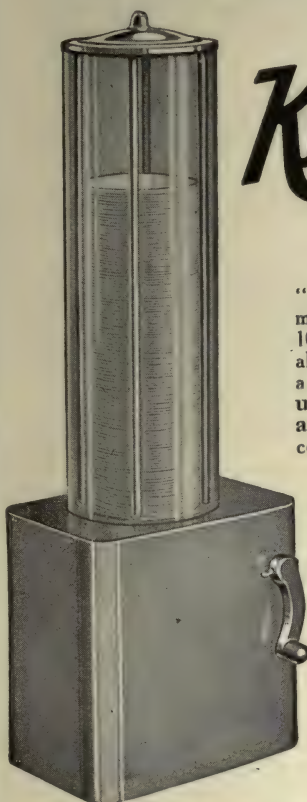
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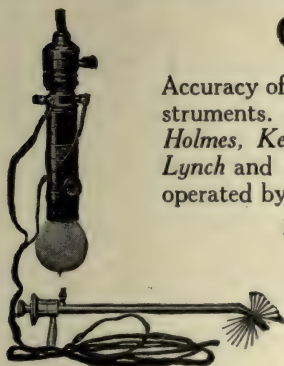
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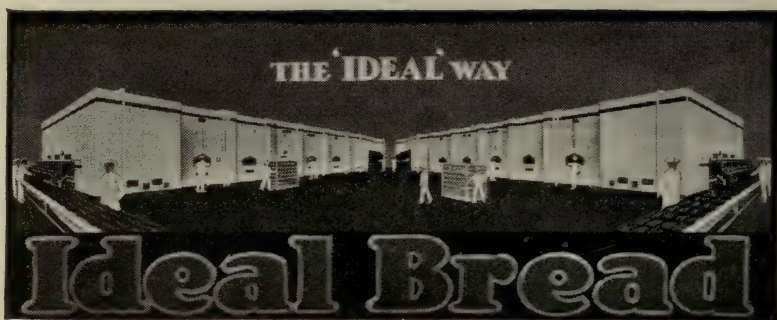
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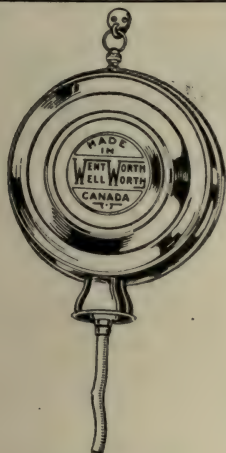
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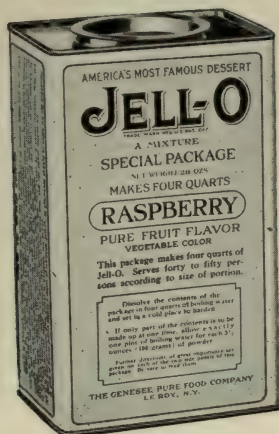
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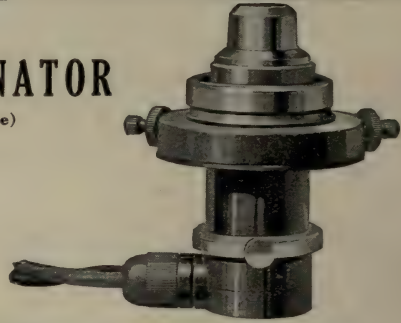
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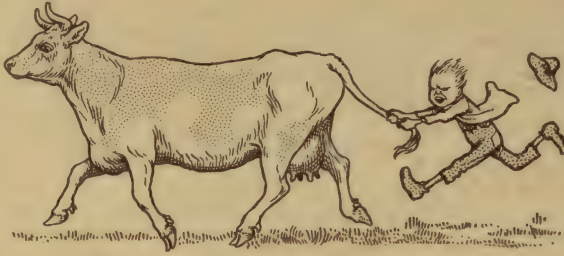
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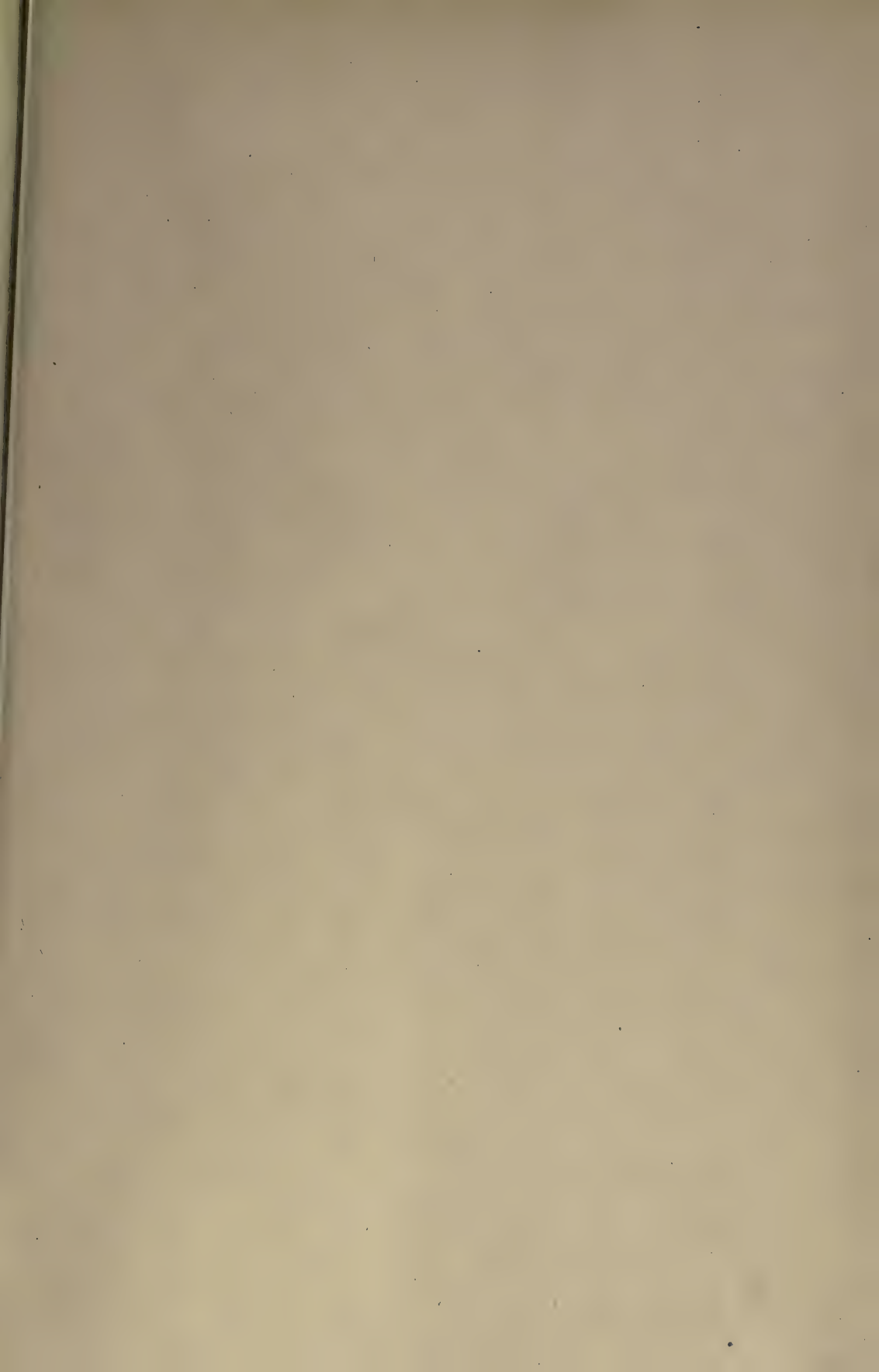
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